HEALTH INSURANCE STUDIES: CONTRACT RESEARCH SERIES

Report No. 1

INTEGRATION OF INFORMATION FOR HOSPITAL RATE SETTING

VOLUME 12: DATA RICH AND INFORMATION POOR: MEDICARE'S RESOURCES FOR PROSPECTIVE RATE SETTING

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INTEGRATION OF INFORMATION FOR HOSPITAL RATE SETTING

VOLUME 12: DATA RICH AND INFORMATION POOR: MEDICARE'S RESOURCES FOR PROSPECTIVE RATE SETTING

by

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PREFACE

The following account of hospital and related Medicare data currently collected and used by the Social Security Administration was written as part of a project that focuses on ways to improve the nature of information available for hospital rate reviews and/or rate setting. The other working papers in this series either describe the nature of the information that state rate reviewers now employ or document various kinds of technical or organizational obstacles they must overcome to secure timely access to new information they need. This paper is written from a different vantage point. It reviews the present Medicare data base from the perspective of its potential uses for hospital rate setting, anticipating that Congress may soon direct a shift to this new form of reimbursement. While federal programs now reimburse hospitals on the basis of the actual costs they incur in providing care to covered patients, the likelihood of change is indicated by the Section 1533 provisions of the National Health Planning Resources and Development Act of 1974 and by the inclusion of some form of prospective reimbursement in almost every important national health insurance bill introduced in recent sessions of Congress. Were such a shift to be made, what information does the Social Security Administration now have that could be deployed to implement the new form of reimbursement? The study here reported addresses this question.

In considering the needs for information that would be generated by the adoption of hospital rate setting under federally financed health insurance programs, any analyst writing in the summer of 1976 is seriously hampered by not knowing the structure Congress may consider appropriate to implement future reimbursement mechanisms; in particular, how responsibilities between federal and state governments and fiscal intermediaries may be apportioned. However, at the minimum, the Department of Health, Education and Welfare would presumably be charged with establishing guidelines and monitoring the performance of any rate setting process administered at regional and state levels, and, at a maximum, might be charged with establishing rate ceilings or even individual hospital rates.

The types of information presently employed and additions considered necessary for more sophisticated rate setting and program monitoring are reviewed in detail in the final report of this project. In brief, to set equitable rates, external reviewers must have data that allow them to take into account various important differences among hospitals as regards output--what they do, and input--the resources they employ to do it. Thus, besides data on volumes of hospital services related to hospital costs and revenues, they need patient profiles showing diagnostic casemix, case complexity and patient age; hospital profiles showing scope of services offered, service complexity and physician specialist mix; the nature, volumes and timeliness of services rendered; geographic differentials in the prices that hospitals must pay for necessary labor and supplies; the efficiency of their service delivery; and the effects on costs of non-patient care service such as teaching. Ideally, the external reviewers should also have data to show differences among hospitals in respect to the appropriateness of patient care rendered in relation to patient needs; the quality of care given; and the outcomes to patients. Finally, for program monitoring, data are needed to show trends in duplications in facilities and services in hospital service areas or regions; trends in hospital indicators of fiscal stability; and trends in per capita utilization and expenditures for hospital services in each region and the relation of both to total health care utilization and expenditures and to trends in the health status of the populations living in these regions.

This is a tall order. Many of these types of information are as yet nowhere available, or are not accessible in a form that allows their systematic use by the nine states and twenty-two Blue Cross plans that now conduct hospital rate reviews, or by those who attempt to evaluate the success of these programs. However, readers of this report will discover that a surprising capability for generating much of this information already exists in the Social Security Administration's data base developed since 1966 to implement the Medicare provisions of the Social Security Act.

The components of this vast and complex data base are a host of

separate reporting systems and surveys, each designed to serve some special purpose, such as determining the eligibility of patients for Medicare benefits, certifying the suitability of institutions to provide care to these beneficiaries, reviewing claims, reviewing utilization, establishing the base for hospital reimbursement on the basis of cost incurred, etc. The author concludes, however, that were the data from these various files and surveys to be employed for the new purpose of hospital rate review program monitoring or rate setting, major changes would be needed in their organization and management, and in the timeliness of their analysis.

This study would not have been possible without the cooperation of the many individuals working in various parts of the Social Security Administration who explained particular aspects of the data components during the course of the interviews. These kind people are listed at the end of the paper. In addition, we are grateful to the staff of the Bureau of Health Insurance and the Office of Research and Statistics of SSA who reviewed the paper for accuracy of content. All interpretations and conclusions are, of course, the sole responsibility of the author.

Katharine G. Bauer
July, 1976

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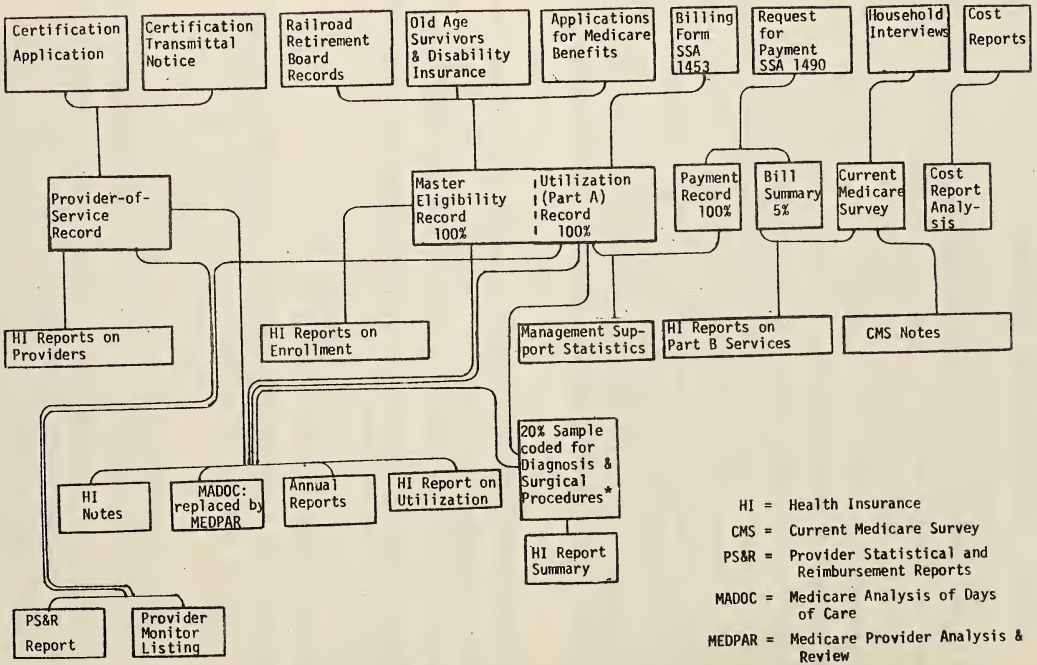
PART I. INTRODUCTION AND BACKGROUND

The federal Health Insurance for the Aged Program, commonly referred to as Medicare, was enacted on July 30, 1965 as Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.). In order to administer and evaluate the Medicare program, the Social Security Administration (SSA) collects, processes and analyzes a wide range of data on program beneficiaries, providers of service, and their interaction. These data come from a variety of sources including Medicare beneficiaries, hospitals and other providers of institutional services, fiscal intermediaries, carriers, and physicians and other suppliers of medical services. While these data are collected and used primarily for administrative purposes, some of the data are also used for research purposes. All of the data are centrally stored on computer tapes at the Social Security Administration headquarters in Baltimore, Maryland.

This report identifies and describes some of the sources of and uses for Medicare program data. Particular emphasis is given to data derived from or pertaining to hospital services and reimbursement under Medicare, Part A. Brief descriptions of the physician-oriented data system are also included to alert the reader to the broad range of data available from the Medicare program, but are not intended to be comparable in detail to the descriptions of the hospital oriented data. Chart 1, to follow, provides the reader with a preliminary overview of the complex derivation and interrelationships between the various sources and uses of Medicare data.

The report is presented in five parts; material in each of them derives from interviews with officials of the Social Security Administration in 1975 and 1976, and from government publications and other relevant readings. In order to familiarize the reader with the general framework of the Medicare program, this introduction provides an overview of the two separate but coordinated insurance coverages under Medicare - hospital

CHART 1: MEDICARE INFORMATION - SOURCES AND USES



*Some analyses are based on a 5% sample derived from this 20% sample.

insurance (Part A) and supplementary medical insurance (Part B). The report next describes the five distinct but interrelated computer tapes that are the basic records for the Medicare program: the Master Eligibility Record; the Provider of Service Record; the Hospital Insurance Utilization Record; the Medical Insurance Payment Record; and the Bill Summary Record. Then, Part III of the report describes the variety of statistical analyses and reports from these basic records for administrative and evaluative use. Part IV focuses on the annual Medicare cost reports and other sources of hospital cost data such as the ORS hospital cost monitoring project. Note should be given to the absence of the Medicare cost reports from the Part II description of the basic records. Since the cost report data have not been integrated with the basic records data, they are separately described. In the fifth and final part of this report, the strengths and limitations of the existing data base are assessed in terms of potential future information requirements for prospective rate setting activities for Medicare.

Section 1: Part A of Medicare - The Hospital Insurance Program

Part A of Medicare, "the Hospital Insurance Program" (or "HI"), covers some of the costs of hospital, skilled nursing facility, and home health care services for Medicare beneficiaries. Persons over 65 who are fully insured under Social Security or who are entitled to Railroad Retirement benefits are automatically eligible for Part A. To be fully insured under Social Security, payroll tax deductions must be taken from the individual or his or her spouse's income for either a total of 40 quarters or for one quarter per year for each year between 1950 and the time the individual turned 65.

The 1972 Amendments to the Social Security Act, P.L. 92-603, expanded Part A eligibility to all persons receiving Social Security disability benefits for at least 24 months and to persons under 65 who are currently or fully insured and who are medically determined to require hemodialysis or renal transplantation for chronic renal disease. Persons over 65 who are not automatically eligible for Part A benefits were also given the

opportunity to enroll in Part A by paying a monthly premium.

Coverage under Part A is limited to 90 days per spell of illness for hospital care, 100 days per spell of illness for skilled nursing facility care, and 100 days per spell of illness for home health care services. A spell of illness is defined as the period beginning on the first day on which the patient is institutionalized in a hospital or a skilled nursing facility for an acute illness and ending after 60 days during which the Medicare beneficiary is not an inpatient of a hospital or skilled nursing facility. In addition to the 90 days of covered hospital care per spell of illness, each beneficiary is given a lifetime reserve of 60 covered days of hospital care from which the individual may draw if hospitalization extends beyond 90 days. However, the 60 day reserve is finite and cannot be renewed. Skilled nursing facility (SNF) services are available only if the beneficiary enters the SNF within 14 days of a hospital stay which lasted at least three days. Similarly, the beneficiary is only covered for home health services if these services follow a hospital stay of at least three days or SNF stay while the beneficiary was covered by Medicare and if the home health care plan was established within 14 days of discharge from the hospital or SNF. During the Medicare beneficiary's lifetime, 190 days of psychiatric hospital care are available. Covered hospital services include room and board, nursing services, drugs, and all those services normally furnished by a hospital to its inpatients.

Part A is funded through Social Security payroll tax deductions, but also includes provisions for some cost sharing by beneficiaries.*

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* On July 1, 1976, the Part A deductible for hospital care was $104 annually plus the cost of the first three pints of whole blood rendered to the beneficiary during a spell of illness. For beneficiaries in skilled nursing facilities and receiving home health agency services, the deductible is the cost of 3 pints of blood, if furnished. For coinsurance hospital services, the beneficiary must pay $26 per day toward the cost of care from the 61st through the 90th day and $52 per day for each lifetime reserve day. In skilled nursing facilities, the coinsurance amount on July 1, 1976 is $13 for the 20th through 100th day of care.

Under Part A, before Medicare will pay anything toward the cost of hospitalization, the beneficiary must pay an annual deductible. Part A also includes a coinsurance provision requiring the beneficiary to pay a fixed amount toward the cost of additional days of care.

Payment for Part A services rendered to Medicare beneficiaries is administered by insurance companies under contract with the Department of Health, Education and Welfare. These insurance companies, called fiscal intermediaries, are selected by the Part A providers and are generally local Blue Cross plans. If a provider chooses not to deal with one of the fiscal intermediaries available in its geographic area, the provider may deal directly with the government and be serviced by the Social Security Administration's Division of Direct Reimbursement (DDR). The administrative structure of Medicare and the roles of the fiscal intermediaries and DDR are discussed in Appendix A of this report. Part A providers are reimbursed on a reasonable cost basis and must accept Medicare payment as full payment. The principles of reimbursement and payment process for Part A are discussed in Appendix B. Beneficiaries may be billed only for deductibles and copayment.

Section 2: Part B of Medicare - Supplementary Medical Insurance

Part B of Medicare, the Supplementary Medical Insurance Program or SMI, covers physician services, hospital outpatient services, services of home health agencies not included under Part A, physical therapy services, diagnostic laboratory and X-ray services, radiation therapy, surgical dressings and devices, durable medical equipment, prosthetic devices, and ambulance services. Home health care services coverage under Part B is limited to 100 days annually, but is subject to the spell of illness requirements of Part A. Payment for outpatient treatment of mental illness is also covered up to $312.50 per year. It should be noted that medical expenses such as the cost of prescription drugs are not covered by Part B.

Everyone eligible for Part A or who is a resident of the United States and over 65 is entitled to enroll in Part B for a monthly premium.

As of July 1, 1976, the premium is $7.20 per month. It is adjusted annually to reflect changes in the cost of providing medical care, but is prohibited by statute (42 U.S.C., § 1395(r)) from exceeding the percentage increase in Social Security payments for that year. For Part A beneficiaries, enrollment in Part B is automatic to avoid problems that occured early in the program when eligible individuals missed enrollment deadlines and were unable to enroll in Part B. Those individuals who are not automatically eligible for Part A must file an application form to enroll in Part B. The monthly Part B premium is deducted from any Social Security payments paid to the individual. If the Medicare beneficiary is also eligible for Medicaid because of poverty, the state Medicaid agency may pay that individual's Part B premium under the terms of what is known as a "state buy-in" agreement.

Part B is funded through the subscriber premiums described above and matched by federal contributions from general revenues. In addition to the premium payments, Medicare beneficiaries must also meet annual deductible and coinsurance cost sharing requirements for Part B services.*

Payment for medical services rendered to beneficiaries is administered by insurance companies selected by the Secretary of DHEW. The insurance companies which administer the physician and outpatient services under Part B are known as "carriers" and are generally the local Blue Shield organization. Only one carrier is selected from each geographic area.

Institutions providing services under Part B are reimbursed on the basis of "reasonable costs", but individual medical vendors, namely

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* As of July 1, 1976 the annual Part B deductible was $60 plus the cost of the first three pints of whole blood used by the beneficiary during the calendar year. For coinsurance for physician services, the beneficiary is asked to meet 20 percent of the Medicare allowable charges. There is no coinsurance for Part B home health care services, but there is a coinsurance of 20 percent of cost or charges on all other non-physician Part B services.

physicians and other practitioners, are reimbursed on the basis of "reasonable charges." Reasonable charges are limited to the lower of either the customary fees of the practitioner or the 75th percentile of the prevailing charges for the same or similar service in the practitioner's community. If a Part B practitioner's customary charges are higher than Medicare's allowable charges, the beneficiary may be billed for the difference. However, if the Part B practitioner "accepts an assignment" of the claim from the Medicare beneficiary, he must accept the Medicare allowable charge payment as full payment. In this case, the beneficiary can be billed only for the deductible and copayment. By "accepting an assignment" of a Medicare claim, the physician can bill Medicare directly and does not have to bill the patient and wait to collect payment from the patient.

PART II. THE BASIC RECORDS FOR THE MEDICARE PROGRAM

The administration of Parts A and B of the Medicare program generates a variety of data that can be used to measure and evaluate program operation and effectiveness. Extensive and systematic information can be obtained on the demographic characteristics of the Medicare beneficiaries, the amounts and kinds of hospital and medical services used by these beneficiaries, and the characteristics of the institutions that provide Part A services. Limited information is also available on the physicians and other suppliers who provide services under Part B.

This range of information is available from related computer tape records:

- the Master Eligibility Record
- the Provider of Service Record
- the Hospital (Part A) Utilization Record
- the Medical Insurance (Part B) Payment Record
- the Bill Summary Record.

It should be noted, however, that the Master Eligibility Record and the Hospital Insurance (Part A) Utilization Record, as well as the Part B utilization records, are actually on the same computer tape and therefore are technically one record. The source and types of data in each of these records are described in Sections 1 through 5 below.

In addition to these master records, a continuing monthly Current Medicare Survey is conducted by the Office of Research and Statistics to supplement the information available in the master records in order to provide more timely estimates of beneficiary utilization of hospital and medical services and the related charges incurred by program beneficiaries. The sample used for the Current Medicare Survey is drawn from the Master Eligibility Record and the Bill Summary Record and therefore can be linked directly to the data available from the five master records. This survey is described in Section 6 below.

Section 1: Master Eligibility Record

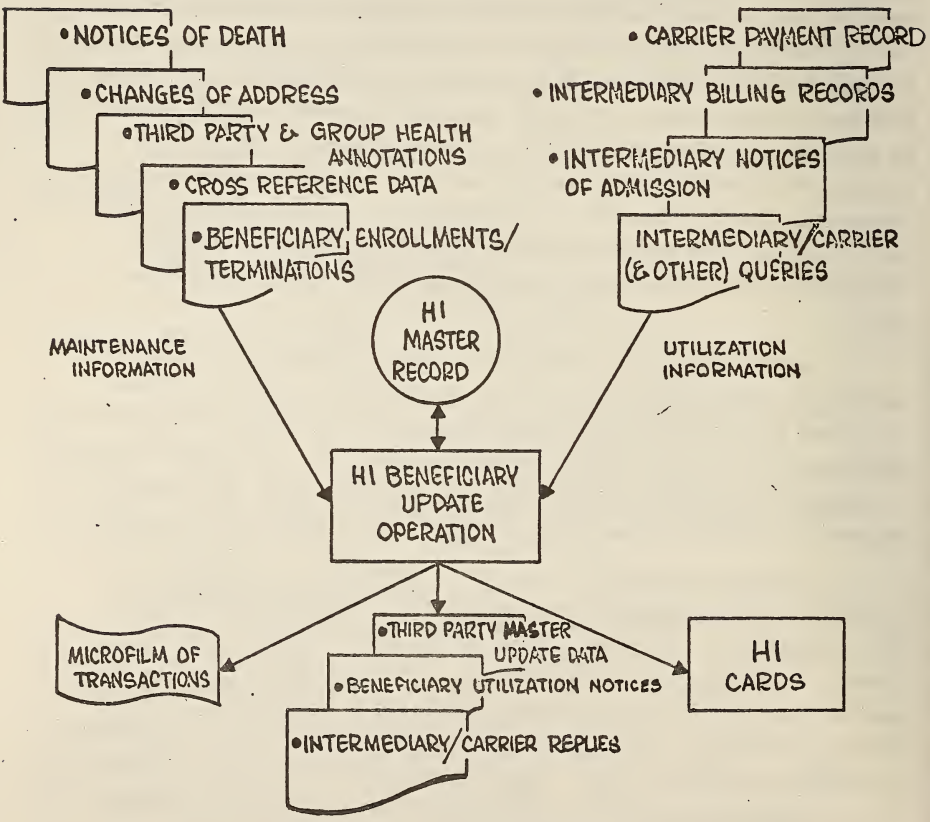
The Master Eligibility Record (also called the Health Insurance Entitlement Master Record) identifies each aged and disabled person who is eligible for health insurance benefits under Title XVIII of the Social Security Act. It shows whether an individual is entitled only to hospital benefits, only to supplementary medical insurance benefits, or to both. The information on eligible persons is compiled from three sources: the Old-Age, Survivors, and Disability Insurance records and Railroad Retirement Board records; applications for hospital insurance benefits (Part A) by aged and disabled persons who are not receiving social security or railroad retirement benefits; and applications for participation in the supplementary medical benefits program (Part B). These sources are also used to maintain and update the Master Eligibility Record by supplying information on the newly aged, those who have died, and those who have moved.

At the initiation of Medicare in 1966, the Master Eligibility file contained records on 19 million eligible individuals. Currently, there are almost 23-1/2 million beneficiary records in the active file and an additional 5-1/2 million records in the inactive files. Each beneficiary is assigned an individual claim number which serves as the link between the Master Eligibility Record and all other records used by the program.

The Master Eligibility Record is the source for information and statistics on the demographic characteristics of Medicare beneficiaries. This information includes the date of birth, sex, race, and state and county of residence for each beneficiary. Since it identifies which beneficiaries are eligible for both Parts A and B, only Part A, or only Part B, this master record can also be used as the base for the computation of various utilization rates. Selected subgroups, such as public assistance recipients who have their supplementary medical insurance premium paid by state welfare agencies (known as "State Buy-Ins"), can also be identified through a code entry in the Master Eligibility Record. However,

EXHIBIT 1: FLOW CHART FOR MASTER ELIGIBILITY RECORD

HEALTH INSURANCE MASTER BENEFICIARY RECORD MAINTENANCE



SOURCE: U.S. Department of Health, Education and Welfare, Social Security Administration. Health Insurance System: A Narrative and Pictorial Description. February, 1975.

a separately maintained State Buy-In Master File, consisting of the state's notices to SSA of coverage of public assistance recipients, is a more reliable source of this type of data.

Section 2: Provider of Service Record

Every hospital, home health agency, extended care facility and independent laboratory is required to apply for certification as a Medicare provider to be reimbursed by the Health Insurance Program. Each institution or agency must meet the conditions of participation specified in Title XVIII of the Social Security Act and the regulations promulgated under that act. The provider's application to establish eligibility as a Medicare provider (SSA-1514) and Certification and Transmittal notice (SSA 1539) are the basic data sources for the Provider of Service (POS) Record, and are both updated annually. The POS file is a subsystem of the Medicare/Medicaid Automated Certification System, instituted in September 1975. Operating through the SSA regional and central offices, this system represents the merger of the Medicare and Medicaid provider files and the automation of the transmission process with daily processing and computer edits and consistency checks at the point of data entry.

The information obtained on each hospital from the application for certification includes the name and address of the hospital; the name of the Chief Administrative Officer; the type of hospital (general, TB, chronic disease, pshychiatric, etc.); the type of control (proprietary, church/voluntary, state government, hospital district, etc.) and the licensure status. Hospitals are also requested to indicate whether the utilization review plan is by hospital staff members, a combination of the Medical Society/Foundation and hospital staff, or a Medical Society/Foundation committee. Hospitals must give their total bed capacity (defined as the number of beds regularly available and set up for use), as well as the number of adult, pediatric, ICU/CCU, and nursery beds. The hospital must check off the services available from a list of 33 possible services such as blood bank, electroencephalograph, emergency department, medical social service

EXHIBIT 2: CERTIFICATION APPLICATION FORM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0717

HOSPITAL REQUEST TO ESTABLISH ELIGIBILITY IN THE HEALTH INSURANCE FOR THE AGED PROGRAM

The instructions for completing Page 1 of this form are on the reverse of Page 2, and the instructions for completing Page 2 are on the reverse of Page 1.

DO NOT WRITE IN THIS SPACE

PROVIDER NUMBER (M1)	STATE/COUNTY CODE (M2)
STATE REGION (M3)	HSA CODE (M4)
PSRO CODE (M5)	PHS CODE (M6)

I. Identifying Information

NAME OF HOSPITAL	STREET ADDRESS
CITY, COUNTY, AND STATE	ZIP CODE / TELEPHONE NUMBER (M7)
NAME OF CHIEF ADMINISTRATIVE OFFICER (M8)	TITLE
NAME AND ADDRESS OF PARENT INSTITUTION *(if applicable)* (M9)	

II. Licensure (M10)

1 ☐ Licensed or Approved as a Hospital by a State or Local Government Agency — 1(a) Name of Licensing Agency *(Specify)*

2 ☐ No License or Approval Required

III. Utilization Review Plan *(Check one)* (M11)

1 ☐ Hospital Staff Members
2 ☐ Medical Society/Foundation Committee
3 ☐ Combination Medical Society/Foundation and Hospital Staff
4 ☐ Other *(Specify)*

IV. Type of Hospital *(Check one that most accurately describes)* (M12)

1 ☐ General–Short Term
2 ☐ General–Long Term
3 ☐ Tuberculosis and other Respiratory Diseases
4 ☐ Psychiatric
5 ☐ Chronic Disease
6 ☐ Specialty–Short Term
7 ☐ Specialty–Long Term
8 ☐ Christian Science Sanitorium
9 ☐ Other *(Specify)*

V. Type of Control *(Check one)* (M13)

Voluntary Not For Profit
1 ☐ Church
2 ☐ Other *(Specify)*
3 ☐ Proprietary

Government (Non–Federal)
4 ☐ State
5 ☐ County
6 ☐ City
7 ☐ City–County
8 ☐ Hospital District or Authority
9 ☐ Government (Federal) *(Specify)*

VI. Bed Capacity

Total (M14)	Adult (M15)	Pediatric (M16)	ICU/CCU (M17)	Nursery (M18)

Hospitals accredited by the JCAH or AOA may establish their eligibility to provide services for reimbursement under the program by submitting to the designated state agency information on this form, and a UR plan which is found to meet the requirements of the law. For other hospitals, the filing of this request will initiate the process of obtaining a decision as to whether the conditions of participation are met. A hospital that establishes its eligibility may later enter into an agreement to become a participating hospital.

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EXHIBIT 2 (Continued)

VII. Services provided by Staff. Place a "1" in appropriate block(s). If under arrangements Place a "2" in the appropriate black(s) (M19)

01 ☐ Blood Bank	16 ☐ X-Ray, Diagnostic	30 ☐ Organ Bank
02 ☐ Clinical Laboratory	17 ☐ Nuclear Medicine	31 ☐ Ambulatory Pre-operative Unit
03 ☐ Pathology Laboratory	18 ☐ Cobalt & Radiation Therapy	32 ☐ Nursery
04 ☐ Electrocardiograph	19 ☐ Psych. Inpatient Care	33 ☐ Shock Trauma
05 ☐ Electroencephalograph	20 ☐ Rehabilitation Unit	
06 ☐ Pharmacy	21 ☐ Extended Care Unit	
07 ☐ Occupational Therapy	22 ☐ Renal Dialysis	
08 ☐ Physical Therapy Dept.	23 ☐ Open Heart Surgery	
09 ☐ Intensive Care Unit	24 ☐ Coronary Care Unit	
10 ☐ Organized Outpatient Department	25 ☐ Oral Surgery Department	
11 ☐ Emergency Department	26 ☐ OB-GYN Department	
12 ☐ Home Care Unit	27 ☐ Pediatric Department	
13 ☐ Operating Room	28 ☐ Speech Therapy Department	
14 ☐ Recovery Room	29 ☐ Pulmonary Function Service	
15 ☐ Medical Social Service Department		

VIII. Number of Medical Staff by Specialty and Type of Appointment

(M20) A. Active	(M21) Consulting	(M22) Courtesy	(M23) Intern	(M24) Resident	(M25) Total

B. Specialties *(Check all applicable)* (M26)

01 ☐ Surgery	06 ☐ OB-GYN	11 ☐ Orthopaedics
02 ☐ Internal Medicine	07 ☐ Urology	12 ☐ Psychiatry
03 ☐ Pathology	08 ☐ Pediatrics	13 ☐ EENT
04 ☐ General Practice	09 ☐ Gastro-Ent	14 ☐ Anesthesiology
05 ☐ Radiology	10 ☐ Neurology	15 ☐ Oral Surgery

IX. Number of Employees (Full Time Equivalents)

A. Nursing Staff

(M27)_____ RN

(M28)_____ LPN

(1) Nursing Subspecialties

(M29)_____ Nurse (CRNA)
(M30)_____ Nurse (Psych.)
(M31)_____ Nurse Practitioner
(M32)_____ Midwives

(Totals should be included in (A), above)

B. Others

(M33)_____ RRA
(M34)_____ ART
(M35)_____ Medical Technician
(M36)_____ Lab Technologist
(M37)_____ Lab Technician
(M38)_____ Dietician
(M39)_____ Nutritionist
(M40)_____ Pharmacist

(M41)_____ Social Worker
(M42)_____ Occupational Therapist
(M43)_____ Speech Therapist
(M44)_____ Physical Therapy
(M45)_____ PT Aides
(M46)_____ Nurse's Aides
(M47)_____ Orderlies
(M48)_____ Physician Assistant

X. Physician Training Programs

A. Affiliated with a Medical School (M49)

1 ☐ Major
2 ☐ Limited
3 ☐ Graduate
4 ☐ No Affiliation

B. Intern Program Approved (M50)

1 ☐ AMA 3 ☐ AOA
2 ☐ ADA 4 ☐ No Program

C. Number of Resident Programs Approved by: (M51)

1 ☐ AMA 3 ☐ AOA
2 ☐ ADA 4 ☐ No Program

SIGNATURE OF AUTHORIZED OFFICIAL

(M52) FISCAL YEAR ENDING DATE:

TITLE | DATE (M53)

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department, speech therapy department, nursery, shock trauma, etc. The hospital must indicate whether these services are provided by staff or under arrangement. For medical staff, the hospital must indicate the number of active, consulting, courtesy, intern and resident staff and the types of specialties of said staff. The number of full time equivalent RNs and LPNs must be given with a separate breakdown of CRNA nurses, nurse practitioners, midwives and psychiatric nurses. The number of full time equivalent medical technicians, lab technologists, RRAs, ARTs, lab technicians, dieticians, nutritionists, pharmacists, social workers, occupational therapists, speech therapists, physical therapists, physical therapy aids, nurse aids, orderlies and physicians assistants must also be indicated. Finally, the hospital must indicate whether it has an American Medical Association (AMA), American Osteopathic Association (AOA), or American Dental Association (ADA) approved intern program; specify the number of resident programs approved by AMA, AOA or ADA; and indicate whether it has a major, limited or graduate affiliation with a medical school.

In addition to the information outlined above, the POS Record also contains the state certifying agency's determination of whether the hospital meets the conditions of participation and is eligible for Medicare certification. This information is obtained from the Medicare/ Medicaid Certification and Transmittal Notice (SSA-1539) which indicates whether the hospital is accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA) and whether hospitals not accredited by JCAH or AOA are completely certified, certified with minor defects or conditionally certified with major improvements needed. A notation is made if the hospital meets only the emergency services hospital definition. The certification and transmittal notice also provides the number of certified beds* as opposed to

* Beds which are used exclusively for services not covered under Medicare (such as custodial care or pediatric intensive care) are not certified for purposes of Medicare reimbursement.

EXHIBIT 3: CERTIFICATION AND TRANSMITTAL FORM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Form Approved
OMB No. 72-R0725

MEDICARE/MEDICAID
CERTIFICATION AND TRANSMITTAL

1. MEDICARE PROVIDER NUMBER (L1)

2. MEDICAID ID NUMBER (L2)

TO BE COMPLETED BY STATE SURVEY AGENCY

3. NAME AND ADDRESS OF FACILITY
(L3)
(L4)
(L5) (L6)

4. TO: DHEW REGIONAL OFFICE

TO: TITLE XIX SINGLE STATE AGENCY

10. PURSUANT TO PROVISIONS OF SEC. 1864 AND APPLICABLE PROVISIONS OF TITLE XVIII OF THE SOCIAL SECURITY ACT AND UPON CONSIDERATION OF ALL FACTS THE FACILITY IS CERTIFIED AS (L12)

(a) ☐ In compliance with program requirements *(If appropriate check applicable boxes below)*

(b) ☐ Not in compliance with program requirements *(If Title XIX only, complete item 13)*

Compliance is based on:
(1) ☐ Acceptable P.O.C.
(2) ☐ CFR sec. 405.1010 (Access provisions)
(3) ☐ P.L. 91-90 (24 Hour RN)
(4) ☐ 1861(j)(15)(7 day RN rural SNF)
and/or approved waiver(s) of the following requirements
(5) ☐ Life Safety Code
(6) ☐ ANSI (Std. A 117.1)
(7) ☐ Organized Medical Staff
(8) ☐ Patient Room Size
(9) ☐ Beds Per Room

(c) ☐ Reapproval Deferred Until _____ *(See Remarks)*

(d) ☐ SNF/ICF Cancellation Date is
(1) ☐ Invoked
(2) ☐ Rescinded

5. CATEGORY OF PROVIDER / SUPPLIER (L7)

01 ☐ Gen. Hosp
02 ☐ Psych. Hosp
03 ☐ TB Hosp.
04 ☐ SNF
05 ☐ HHA
06 ☐ Independent Lab
07 ☐ Portable X-Ray
08 ☐ Outpatient PT/SP
09 ☐ Chronic Dialysis Unit
10 ☐ ICF
11 ☐ IMR

11. SNF / ICF PERIOD OF CERTIFICATION (L13)
(a) FROM (b) TO
(c) CANCELLATION DATE (SNF/ICF) (L14)

6. TYPE OF ACTION (L8)
1 ☐ Initial
2 ☐ Recertification
3 ☐ Reconsideration
4 ☐ Change of Ownership
5 ☐ JCAH AOA Validation
6 ☐ JCAH/AOA Investigation

12. SUPPLEMENTAL INFORMATION ON HOSPITALS AND SNF'S NOT IN COMPLIANCE (L15)
(a) Hospital meets emergency services hospital definitions (1) ☐ Yes (2) ☐ No
(b) Facility meets 1861(e)(1) - Definition of hospital (1) ☐ Yes (2) ☐ No
(c) Facility meets 1861(j)(1) - Definition of SNF
(1) ☐ Yes (2) ☐ No (3) ☐ See attached SSA 1539 (s)

7. DATE OF APPLICATION *(Initial certification ONLY)* (L9)

8. ACCREDITATION VERIFIED *(Hospitals)*
1 ☐ JCAH 2 ☐ AOA (L10)

CHANGE IN ACCREDITATION-BASED CERTIFICATION *(Hospitals)*
1 ☐ Gained Accreditation
2 ☐ Lost JCAH Accreditation
3 ☐ Lost AOA Accreditation (L11)

13. SUPPLEMENTAL ICF INFORMATION (L16)
(a) Completion date for ICF LSC compliance
(b) 249.13 ICF Phase-in Date

14.

TOTAL OR DISTINCT PART CERTIFICATION	HOSPITALS	XVIII SNF	XVIII/XIX SNF	XIX SNF	XIX ICF	XIX IMR
BEDS CERTIFIED (L17)	(a)	(b)	(c)	(d)	(e)	(f)
BEDS PREVIOUSLY CERTIFIED (L18)	(g)	(h)	(i)	(j)	(k)	(l)

15. STATE SURVEY AGENCY REMARKS

16. SURVEYOR SIGNATURE	17. DATE (L19)	18. STATE SURVEY AGENCY APPROVAL	19. DATE (L20)
TITLE		TITLE	

TO BE COMPLETED BY THE DHEW REGIONAL OFFICE OR SINGLE STATE AGENCY

20. DETERMINATION OF ELIGIBILITY
1 ☐ Facility is eligible to participate
2 ☐ Facility is not (or no longer) eligible to participate *(If Title XIX only, complete item No. 26)* (L21)

21. ☐ Facility is in compliance with Title VI of Civil Rights Act (L22)

22. ☐ Statement of financial solvency filed in accordance with regulation 405.603. (L23)

23. EFFECTIVE DATE OF *(Enter All Applicable)*
(a) PARTICIPATION (L24)
(b) AGREEMENT ENDING DATE (SNF) (L25)
1st CANCELLATION DATE (SNF) (L26)

16. SNF/ICF AGREEMENT EXTENDED UNDER SEC. 1866(e)(1)(C) OF SOCIAL SECURITY ACT UNTIL (MAXIMUM OF 90 DAYS) (L27)

(a) TERMINATION OR NON-RENEWING DATE (L28)

17. EMERGENCY SERVICES (L29)

24. VOLUNTARY TERMINATION (L30) 1 ☐ CLOSURE 2 ☐ WITHDRAWAL 3 ☐ OTHER *(Specify)*

25. INTERMEDIARY NUMBER (L31)

26. REMARKS

27. PHS REVIEW *(Where applicable)*	28. DATE (L32)	29. DETERMINATION APPROVED	30. DATE (L33)

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total bed capacity of the hospital.

For hospitals which are not JCAH or AOA accredited, the state agency must itself perform an annual certification survey, similar in scope to the JCAH accreditation survey. For these non-JCAH accreditated hospitals, the POS file contains the results of the annual survey which shows the types of deficiencies present at the time of the survey, the staffing pattern, the kinds of consultants employed by the hospital, the nursing roster, the number of nursing hours for every nursing shift, the number of board certified surgeons, the administrative structure, and the results of the fire and safety code review. Since 4900 hospitals participating in Medicare were JCAH accredited in 1974, this wider scope of information is available only for the 1780 providers without JCAH accreditation.

Earlier in the Medicare program, the POS file also contained the interim reimbursement rate of each provider obtained from form SSA-1885. However, this information was eliminated from the POS file on the recommendation of the HEW Audit Agency. Consideration is now being given to eliminating the interim report altogether.

The POS Record does not contain any data derived from the Medicare cost reports. While it seems natural that the provider's cost report would be integrated with the statistical data, it is maintained that the severe delays in getting the cost reports from the provider to the fiscal intermediary to SSA and keypunched and coded once at SSA make their inclusion in the POS files too troublesome. The certification data are transmitted directly from terminals in the Regional Offices of DHEW to the Bureau of Data Processing at SSA and thus are not subject to the transmission and processing delays of the cost reports. However, because the hospital certifications are staggered throughout the year to distribute the survey burden on the state agencies, updated certification data is continually being received by SSA. As a result, there is a lack of synchronous data for research requiring comparable time frames.

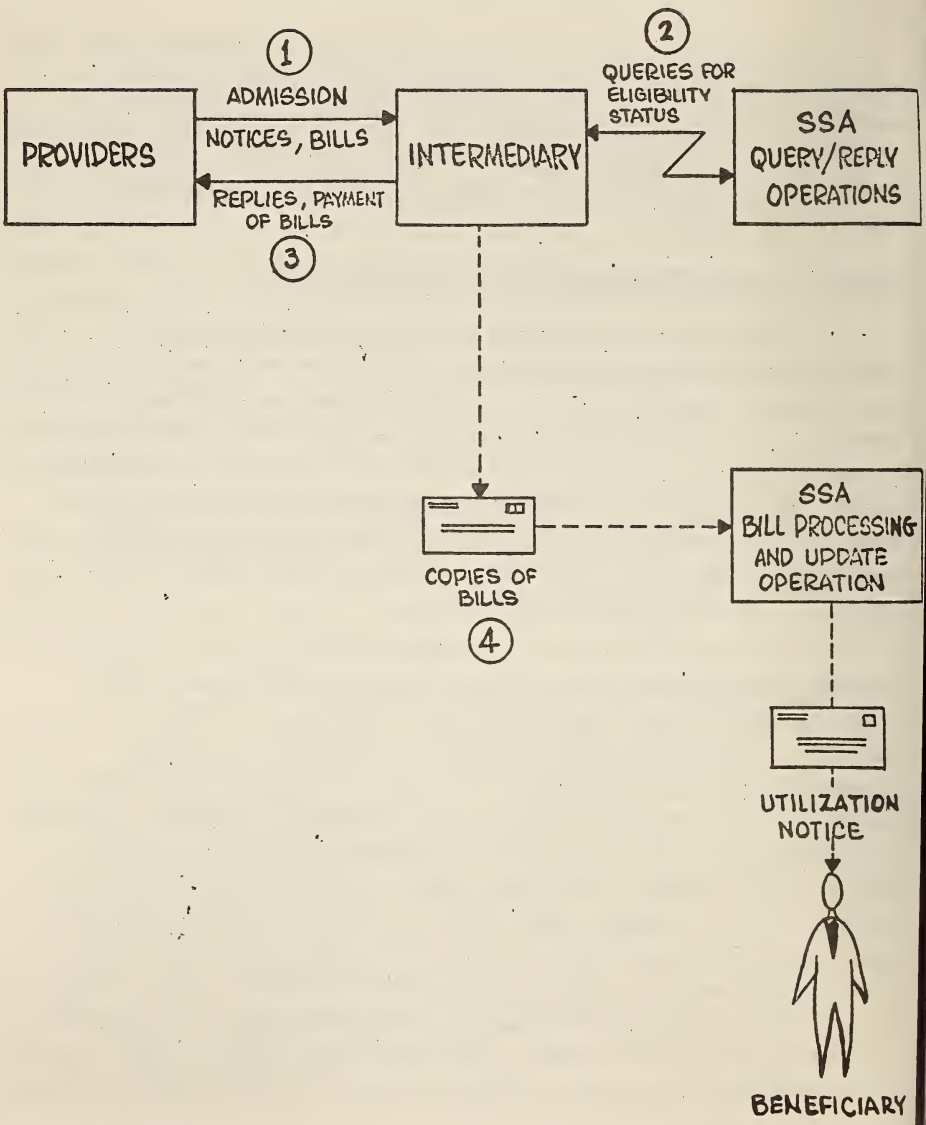
Despite the failure to incorporate cost report data into the POS Record, this master file is still a comprehensive and useful source of statistical data on Medicare providers. When the information in this file is combined with utilization data, the characteristics of facilities that provide care can be related to the kinds and amounts of services used by Medicare beneficiaries.

Section 3: Hospital Insurance (Part A) Utilization Record

The Hospital Insurance (Part A) Utilization Record, hereafter referred to as the Utilization Record, is the file containing each bill paid under Part A of Medicare (i.e., a 100% file) and, for a 20% sample of beneficiaries, records of diagnoses and surgical procedures. Each episode of hospitalization by each individual beneficiary is recorded in the master record. This information is derived from the admission notices and billing forms that are submitted by participating hospitals every time a Medicare beneficiary is admitted or discharged. The flow of billing data from the hospital to SSA is reviewed in Exhibit 4.

The Part A Billing Form (SSA-1453), reproduced here as Exhibit 5, contains the beneficiary's name, address, Medicare claim number, sex, date of birth, medical record number, and date of admission. The name and address of the hospital, hospital's provider number, and name of the attending physician are also given. The admitting diagnosis, the types and dates of all surgical procedures, and the primary and secondary discharge diagnosis are requested. Total charges and non-covered charges for blood administration, pharmacy, radiology, laboratory, medical/surgical and central supplies, physical therapy, speech pathology, inhalation therapy, operating room anesthesia, and outpatient services must be given. The number of days; rates per day; and total charges and non-covered charges for intensive care, coronary care, 1 bed accomodation, 2-3-4 bed accomodations, or 5 or more bed accomodations must also be shown. Information on the number of blood pints furnished and replaced, charge per pint, total charge, and non-

EXHIBIT 4: HOSPITAL INSURANCE CLAIMS PROCESS



SOURCE: U.S. Department of Health, Education and Welfare, Social Security Administration. Health Insurance System: A Narrative and Pictorial Description. February, 1975.

EXHIBIT 5: PART A INPATIENT HOSPITAL BILLING FORM

INPATIENT HOSPITAL AND EXTENDED CARE ADMISSION AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved OMB No. 72-R0734

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name	First name	MI	2. Sex ☐M ☐F	3. Health insurance claim number
4. Patient's address (Street number, City, State, ZIP Code)			5. Date of birth	6. Medical record number
7. Date of this admission	8. Provider name and address (City and State)		9. Provider number	10. Attending physician
11. Dates of qualifying stay FROM / THRU	12. Qualifying and other prior stay information			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you went information about this claim released to them upon their request, complete items 13 and 14.

13. Insuring organization and / or State agency name and address	14. Policy and / or medicel assistance number

15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a releted Medicare claim. I request that payment of authorized benefits be made on my benalf.

☐Contained in provider's record	Signature (Patient or authorized representative) (Signeture by merk must be witnessed)	Date

16. Admitting diagnoses (If employment related, also give name and address of employer)	Do not use this space	17. Discharge or current diagnoses (a) Primery (b) Secondary	Do not use this space
18. Surgical procedures (Show dete of each)			

19. STATEMENT OF SERVICES RENDERED	Blood pints furnished	Pints replaced	Not replaced	Charges per pint	Total Charges	Non-covered Chg's
A. Accommodation			Days	Rate		
B. 1-Bed						
C. 2-3-4 Bed						
D. 5 or more Beds						
FOR HOSPITAL ONLY E. Intensive care						
F. Self care						
G. PIP total						
H. Operating room						
I. Anesthesia						
J. Outpatient services						
K. Blood administration						
L. Pharmecy						
M. Radiology						
N. Laboratory						
O. Medical, surgical and central supplies						
P. Physical therapy						
Q. Occupetional therapy						
R. Speech therapy						
S. Inhalation therapy						
T. Other (Describe)						
U. TOTALS						
V. Inpatient deductible						
W. Blood deductible pts. @						
X. Coinsurance days ( ) ( )						
Y. TOTAL DEDUCTIONS						

20. Statement covers period FROM / THRU	
21. Dete guarentee of payment began	22. Dete UR notice received
23. Dete active care ended	24. Dete benefits exhausted
25. Patient status A. Dete discherged	B. Dete of death / C. ☐Still patient
26. Lifetime reserve days used	27. Non-covered days / 28. Covered days
30. Remarks: PIP per diem amount $	
31. Reimbursement amount $	
FOR INTERMEDIARY USE 32. Verified non-covered stays From / Thru	33. Non-pmt. code / 34. Days used

29. I certify that the required physician's certification and recertifications are on file.

Signature of provider representative	Date received	35. Approved by	Date approved

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INFORMATIONAL COPY

Department of Health, Education, and Welfare
Social Security Administration

covered charge is also requested. The patient's status in regard to Medicare benefits (i.e., number of days used from lifetime reserve, number of covered versus non-covered days, etc.), the discharge date, and the date of utilization review notice are also given. For deceased patients, the date of death is indicated.

In summary, billing form SSA 1453 enables SSA to obtain detailed information on each hospitalization, including:

- the period of use (date of admission and of discharge, the length of stay, and the discharge status);
- the primary diagnosis;
- the surgical procedures performed; and
- the total charges and non-covered charges for each service rendered.

However, while the billing form contains this information for each beneficiary's hospital stay, the diagnostic and surgical procedures data are not coded for 100% of the bills submitted to SSA.

The diagnostic and surgical procedure data is only coded for a 20% sample of beneficiaries selected on the basis of specific combinations of digits in Health Insurance claims numbers, specifically, those ending in 0 or 5. These Medicare sample sizes are shown in Exhibit 6. This 20% sample represents approximately 1.5 million of the 7.5 million bills submitted annually to SSA for hospital services to Medicare beneficiaries. Moreover, this 20% sample represents 30% of all hospital days for all patients in the U.S. However, the quality of the diagnostic and surgical procedure data drawn from these forms is generally regarded as poor because the claims form is completed by clerks in the hospital billing departments who are not familiar with medical terminology instead of by the medical records department staff who are trained to abstract and interpret medical records.

SSA's Office of Research and Statistics (ORS) is now developing computer programs to code the diagnostic and surgical procedures section of the billing form and hopes that this will facilitate the coding of diagnostic and surgical procedures for the 20% sample. Currently, the 20% sample is

EXHIBIT 6: MEDICARE SAMPLE SIZES FOR DIAGNOSIS AND PROCEDURE CODING

Revised--4-6-72
GStickler:cmv

Medicare Sample Sizes for Diagnosis and Procedure Coding

Type of Medicare Benefit	Billing Form	Sample Size	Remarks
Inpatient Hospital	SSA-1453	20%	HI claim numbers ending in 0, 5.
Extended Care Facility (ECF)	SSA-1453	100%	
Medical & Other Health Services (Outpatient Hospitals)	SSA-1483	5%	HI claim numbers ending in 05, 20, 45, 70, 95 for services in 1971 or later.
		20%	HI claim numbers ending in 0, 5 from July 1968 thru services in 1970.
		40%	From July 1966-June 1968.
Home Health Agency - Part A & Part B	SSA-1487	40%	HI claim numbers ending in 0, 4, 5, 8. Part A was 100% up until May 1969.

Diagnostic Coding for Services thru 1970 - ICDA 7

Diagnostic Coding for Services after 1970 - ICDA 8

Surgical Procedure Coding for all years - CPT

is coded manually. It should also be noted that although the billing form asks for both a primary and secondary diagnosis and all surgical procedures, the 20% sample is only coded for the primary discharge diagnosis and the first surgical procedure listed. However, the computer record does have an indicator to show if multiple diagnoses or surgical procedures were given on the billing form.

The information derived from the 20% sample forms constitutes the "stay record". This stay record is the basis for all Medicare inpatient hospital utilization statistics as well as many derivative files such as the MADOC and MEDPAR reports that are discussed later. The stay record does not contain information on the beneficiary's outpatient activity. Since each admission and billing form contains both the beneficiary's claim number and the provider's Medicare identification number, the resulting tape can be matched to the Master Eligibility Record and the Provider-of-Service Record. By this process, a statistical tape record is created for the 20% sample of insured persons that contains all the available information needed for tabulation from the three files related to Part A Utilization. Utilization histories based on the stay record can be constructed covering a variety of statistical variables - the admission and discharge rates, length of stay, discharge status, charge and payment data (including figures on non-covered charges, deductible amounts, and co-insurance amounts), primary diagnoses, surgical procedures, and pre-operative and post-operative lengths of stay. Utilization histories on length-of-stay and other non-diagnosis related variables can be produced from the 100% utilization record which is coded for all information except diagnosis and surgical procedures.

The Part A Utilization Record also provides for the recording of stays or parts of stays in non-participating hospitals and in participating hospitals that are not covered under the program because the beneficiary has already exhausted his benefit rights during his current spell of illness. However, the Office of Research and Statistics staff warn that this information may not be very reliable.

Section 4: Medical Insurance (Part B) Payment Record

Administration of Part B of Medicare does not require the extensive certification, admission, and billing procedures of Part A, Hospital Insurance. All licensed physicians, osteopaths and chiropractors are eligible to participate in the program, eliminating the need for the establishment of a detailed record of certified providers like the Part A Provider-of-Service File. In addition, Part B does not have the "benefit period/spell of illness" restrictions of Part A. After the carriers determine that the Part B deductible has been met for the calendar year, no additional information is required for reimbursement purposes unless the claim involves psychiatry, physical therapy, or Part B blood charges.

However, SSA does need complete and accurate information on the amounts paid by carriers for physicians and other medical services. To meet this need, the Part B carriers supply SSA with a payment record which is a tape record of each claim for which reimbursement is made in behalf of a beneficiary as a result of services provided by a single physician or supplier. But if all charges are applied to the deductible, no payment record is prepared.

The payment record is a 100% file which means that it contains all reimbursable claims and not just a sample of the total claims. The payment record provides SSA with the following information for each reimbursable Part B claim: the beneficiary's claim number, the date the bill was received, the date the bill was paid, the total non-physician medical charges, the total physician medical charges, the amount to be applied to the deductible, the reimbursement amount, the code number of the physician or supplier, the place of service, the type of service, the number of separate charges constituting the total charge, and the type of physician or supplier. The payment record formerly included the dollar amount of the most expensive procedure, but that has since been replaced with the dollar amount of total reasonable charges. It should be noted that data on diagnoses and procedures and related charges are not included in the payment record. The payment record also does not

include pre-deductible and non-covered services.

Section 5: Bill Summary Record

The Part B Payment Record provides a rapid method for summarizing payment data and a sampling frame for efficiently drawing additional samples of bills, but does not provide specific data on diagnoses, procedures, and related charges. Formerly, this information on Part B utilization was derived from a continuous sample of the bills paid to or in behalf of 5% of all enrolled persons.

Under the 5% sample system in operation until 1972, hard copies of the Part B Request for Payment (SSA-1490) were sent to SSA for coding and processing. These forms provided information on the time and place of each service, the exact procedure carried out or service provided, the condition treated (diagnosis), and the physician or supplier's charge. The data gathered in the 5% sample reflected bills paid. For beneficiaries in the sample, all bills, including those used to meet the annual deductible, were included and coded. However, data was not available on those beneficiaries in the 5% sample who never reached the deductible or for whom the bill was never received. This type of information is collected by means of the Current Medicare Survey described in the following section.

In 1972, the 5% sample of Medical Insurance bills was eliminated due to severe problems with the volume of paper generated by using the hard copies (i.e., copies of the actual requests for payment) and because of resistance both within SSA and from the carriers. However, despite the difficulties, many feel that the elimination of the 5% sample was a mistake and creates a serious gap in the data available for program analysis.

As a result, after having no sampling system for Part B in 1973 and 1974, SSA instituted a 5% sample summary record for Part B services provided in or after 1975. The data contained in this record are: the Health Insurance Claim number and sex of the beneficiary, the month and

year of the expense, the total submitted charges, the total reasonable charges, the total reimbursement amount, the total applied toward the deductible, the physician or supplier's specialty code, the physician or supplier identification number, an indication of whether the physician accepts assignment, the carrier number, and the type of request for payment. In addition, there is an indication of the type of service, place of service, service charge, and service reasonable charge for each separate service. The carrier prepares a computer tape for SSA containing this information for a 5% sample of beneficiaries selected on the basis of specific combinations of digits in their Health Insurance claim number.

Unlike the 5% sample system used until 1972, the new Bill Summary Record does not contain information on diagnosis or surgical procedures and is therefore only useful as a means of providing a profile of charges for a given service. It should also be noted that since the system was only put into operation in July 1975, it is difficult to assess its effectiveness as a means of obtaining information on Part B utilization at this time.

Section 6: Current Medicare Survey

The continuing monthly Current Medicare Survey (CMS) is conducted by SSA's Office of Research and Statistics (ORS) to obtain current estimates of medical services used and charges incurred by Medicare beneficiaries under Parts A and B or the program. It is an important adjunct to the utilization and reimbursement information obtained from the benefit-payment administrative operation since final data obtained from the administrative process is not available until the hospital and medical bills have been sent to and paid by the intermediaries and carriers and processed centrally by SSA. Because the time limit for filing Part A or B claims ranges from 15 to 27 months from the date on which services were rendered, the survey must be used to obtain timely utilization information. Moreover, the Current Medicare Survey is the only source of statistics about the use of and expenditures for non-covered services by Medicare enrollees. By

obtaining information on the utilization and cost of these non-covered services, the Current Medicare Survey is a valuable base for estimating the potential of expansion of Medicare benefits.

The medical insurance sample of the Current Medicare Survey is composed of a household interview sample of 7000 aged and disabled beneficiaries enrolled in the Supplementary Medical Insurance program (Part B). Since the elimination of the 5% Supplementary Medical Insurance sample that was coded for diagnosis and surgical procedure in 1972, the CMS has been the data source that provides information on the total number and kind of physicians and the types of services (office visits, surgery, etc.) used by Medicare beneficiaries.

The CMS sample is selected from the Part B Eligibility Record by the ORS. The actual data collection and field interviewing is conducted by the Bureau of the Census, but analysis of the data is done by ORS.

Once a month, a representative of the Bureau of Census contacts each of the beneficiaries in the sample to obtain information on his or her use of medical care and related services during the preceding month. The questionnaire is designed to elicit the name and address of the respondent, the date and place of any physician visit, the type of physician visited, the condition treated and other medical services received, the amount of the bill, the portion not covered by Medicare, and the source of payment. The charges are accumulated for each beneficiary so that the total covered amount for an enrollee may be located from any point below the deductible ($60 as of July 1, 1976) for physician services to any point above.

Each medical insurance sample group is surveyed for a 15 month period which begins each October and continues through December of the following year. A 15 month cycle is used because expenses incurred by an enrollee in the last three months of the calendar year and applied to the deductible for that year may be carried over and applied to the deductible for the next calendar year. Since a new household survey is

begun each October, for the months of October, November, and December, two surveys are conducted simultaneously.

The survey data are used as the basis for several types of analysis done by the Office of Research and Statistics. Estimates of the number of medical services, places and types of services, charges for these medical services, potential reimbursement from SSA, and source of payment for the portion not covered by Medicare can be made. In addition, the survey permits the generation of estimates of the use and costs of prescription drugs and other non-covered services (out-of-pocket payments for routine physical examinations, dental services, eyeglasses or eye examinations, and hearing aids) and utilization of and estimated expenses incurred for the service of non-covered practitioners (optometrists, naturopaths, and Christian Science practitioners). Data are also obtained on how use of and charges for medical services are related to the socio-economic characteristics of the medical insurance enrollees and on the impact of cost-sharing of the deductible and co-insurance provisions on beneficiaries.

Section 7: Discussion

The records described in the above sections constitute the principal Medicare data base. The basic records and samples derived from them are used to generate most of the statistical analyses and reports on the Medicare program. As previously noted, the Medicare provider cost reports are not included in the basic records system, but instead form a separate component that is discussed in Part IV.

Several aspects of the Medicare basic records warrant discussion. The Medicare program is a rich source of data on the hospital utilization patterns of over 23 million elderly and disabled Americans. The population served is individually identifiable through their health insurance claim number which can be used to link demographic data in the eligibility record (age, race, sex, county and state of residence) to utilization data derived from the claims form. The certification file provides profiles

of the facilities that serve the program beneficiaries and can be linked to the utilization data by the provider claim number that appears on both the certification and claims billing forms. Expenditure data by state and county or by institution, if desired, can also be generated from the claims billing forms. Thus, the data available from the Medicare program contains four of the essential ingredients for a population based data system: demographic data, resource data, utilization and expenditure data. Additional aggregate expenditure data by institution are also available from the cost reports, but, as will later be discussed, this data is not currently linked to the master files. Another ingredient of a population-based data system not readily available from Medicare is outcome data. However, some morbidity and mortality estimates can be made on the basis of the 20% sample of the Part A utilization record and the Current Medicare Survey.

The purpose for which the basic records were designed and their primary use must be recognized. These records were designed to produce the information necessary to administer the Medicare program and the data contained in the records reflect administrative needs. For example, the basic records are used to quickly check whether an individual is eligible for Medicare benefits or the number of days of hospital coverage remaining for a Medicare beneficiary. However, a determination of the number of times a given procedure is performed at Hospital X is not so readily accomplished. In fact, such a determination would not be feasible since diagnostic and surgical procedure data are only coded for a 20% sample of beneficiaries and the output, i.e., the number of times a given procedure is performed at one institution, would be irrelevant for any current program need.

The current system is keyed to the beneficiary and not to the provider. The utilization data in the basic records are linked to the Master Eligibility Record and not to the Provider of Service Record. Utilization data are coded and stored by beneficiary claim number, although some information such as charges incurred, can be printed out by provider. However, the beneficiary orientation of the system is not a major obstacle

because the computerized data can be sorted out by provider instead of beneficiary, if desired.

The linkage of provider certification data in the Provider of Service Record and provider cost data from the cost reports is not so easily accomplished. Under the existing system, cost report data is separately maintained and not integrated into the Provider of Service Record. The reason given for the separation is that the cost report information is one to two years old before it reaches SSA and attempts to include these data would only serve to hamper attempts to keep the Provider of Service Record current.* Some of the SSA staff interviewed felt that the data in the Provider of Service Record was not very reliable because there is no link between the quality or accuracy of the certification information and the amount of provider reimbursement.

As already noted in discussion of the Current Medicare Survey, special surveys are conducted to pick up non-covered utilization in non-participating hospitals. Since Medicare does not provide total coverage, such surveys are both necessary and useful as means to determine out-of-pocket expenditures and fill the gap in utilization information. The fact that such surveys are conducted is a positive feature of the Medicare information system.

Another positive feature is the use of samples as the basis for many of the statistical analyses. It would be expensive both in terms of dollars and staff time to code every billing form for diagnosis and surgical procedure. However, it should be noted that diagnoses and surgical procedures are only coded for inpatient hospital services because the Part B Payment Record and Bill Summary Record do not contain this type of data.**

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* A fuller discussion of this is provided in Part IV on Hospital Cost Data.

** The abandonment in 1972 of the 5% sample of supplementary medical insurance claims unfortunately eliminated this valuable source of utilization data from the SSA statistical system. BHI staff note, however, that sample data, including procedural codes, are collected for outpatient services on SSA form 1483.

An additional problem with the surgical and diagnostic information available for inpatient services is that where the billing form lists more than one diagnosis or procedure, only the first procedure or diagnosis listed is coded, although the presence of multiple entries is indicated. Thus, a true reading of case complexity cannot be obtained.

The basic records of the Medicare program provide a guide to what has happened within the Medicare program. In essence, these records are the computerized history of the Medicare beneficiaries, the providers of care and services received. The next section describes the way in which the historical data of the program are analyzed and reported.

PART III. ANALYSES DERIVED FROM MEDICARE MASTER RECORDS

The Medicare basic records described in the preceding part are used by the Bureau of Health Insurance (BHI) and the Office of Research and Statistics (ORS) to generate statistical analyses of program operations. BHI uses the basic records to produce the Provider Statistical and Reimbursement Report to assist the fiscal intermediaries in settling the provider cost reports and the Provider Monitor Listing to assist the fraud and abuse staff in identifying out-of-line providers. ORS relies on the master records for data used to prepare the Health Insurance Notes series, the Current Medicare Survey Notes series, and the annual Medicare Statistical Report series. Until recently, ORS also prepared workload and processing time statistics for the Medicare carriers and intermediaries based in part on the data from the master records. However, the unit responsible for this activity has been recently transferred from ORS to BHI. As a result, these management support statistics on intermediaries and carriers are now produced by the Bureau of Health Insurance. Each of these analytical reports is described in the sections which follow.

Section 1: Settling the Provider's Payment Request - the Provider Statistical and Reimbursement Report

The Provider Statistical and Reimbursement Report, commonly referred to as the PS&R report, is prepared quarterly by the Bureau of Health Insurance and forwarded to the fiscal intermediaries for use in reconciling the provider cost reports. The PS&R report is derived from the Provider of Service Record containing the certification information on providers and the Hospital Insurance (Part A) Utilization Record containing the charge information obtained from the provider billing transactions. Because the PS&R report is used to reconcile the cost report data with the billing data, the PS & R report is not derived from cost report data.

The charge data from the Medicare billing forms (SSA-1453) is

reproduced and described in the preceding section on the Utilization Record) is keyed on magnetic tape and entered into the beneficiary's eligibility and utilization record. These charge data are then sorted out by provider number and a separate computer printout is generated for each provider. This computer printout, the PS&R report, displays the total Medicare charges and reimbursement amounts for the providers' accepted bills, bills returned to the intermediary, pending bills, and total bills. Data from the current and three preceding fiscal years are shown. The charge information is keyed to the different departments of the hospital as reported on the billing form.

The PS&R report was designed by SSA as a mechanism to assist the intermediaries in settling the provider's annual cost reports. However, many of the larger intermediaries have internal computer systems which prepare more up-to-date and complete PS&R reports than those generated by SSA and therefore these intermediaries use their own systems to settle the cost reports. As a result, in 1973, BHI proposed that the PS&R system be abandoned and the intermediaries be asked to prepare their own PS&R reports. However, several intermediaries maintained that they still needed the PS&R report to accomplish their cost settlements. Therefore, for these 40 intermediaries, BHI continues to print-out PS&R reports for those providers under their jurisdiction. PS&R reports are not provided to those intermediaries with in-house settlement capability.

Section 2: Identifying Fraud and Abuse - the Provider Monitor Listing

The Provider Monitor Listing is prepared on a semi-annual basis to enable the Program Integrity staff of the BHI central and regional offices to detect providers with abnormal charge situations. This report is derived from the same data as the PS&R report, but the data items are arrayed differently. The Provider Monitor Listing is produced by combining data from the Provider of Service record and the Part A and B billings that make up the utilization record and form the basis of the

PS&R report.

Provider Monitor Listings are prepared by BHI for both hospitals and nursing homes. In the Provider Monitor Listing for hospitals, hospitals are grouped into 4 categories: proprietary, governmental, long-term and other. A separate listing is generated for each of these categories with each listing further divided into 5 bed size sub-categories. Within each category and sub-category, the individual providers (identified by name) are ranked according to the dollar amount of their per diem and service charges; the provider with the highest charges is listed first. The types of service charges and variables for which a listing is generated are: operating room, routine charges, inpatient pharmacy, inpatient radiology Part A and B, physical therapy, medical-surgical supplies, laboratory Part A and B, per diem reimbursement charge, inhalation therapy, total covered charge, reimbursement, Part B outpatient laboratory, Part B outpatient radiology, Part B outpatient physical therapy, and length of stay.

For each provider, a comparative score is computed by adding the provider's individual rankings in operating room, routine charges, pharmacy, radiology, laboratory, medical-surgical supplies, physical therapy, per diem reimbursement charge, inhalation therapy, per diem charges, per diem reimbursement, and length of stay and dividing the sum by the number of entries added. Hospitals are then listed in descending order (i.e., hospitals with highest per diem amounts are listed first) based upon this computation. The comparative rankings are prepared on a national basis and then broken down by HEW region and by intermediary jurisdiction. By reviewing the Provider Monitor Listing, one can pick out the hospitals with the highest per diems or highest service charges in each region.

The Provider Monitor Listing is primarily used by BHI's Program Integrity Staff which has responsibility for identifying and controlling provider fraud and abuse against Medicare. The Program Integrity staff uses the Provider Monitor Listing as an alert system to flag providers with excessively high charges. Further investigations through on-site audits

are conducted on those providers who seem out-of-line. However, this report is not used by BHI's Division of Provider Reimbursement and Accounting Policy for the setting of ceilings for Section 223.

Section 3: Assessing Claims Administration - Management Support Statistics

As is discussed in Appendix A's account of the administration of Medicare, the Bureau of Health Insurance contracts with fiscal intermediaries to administer Part A (Hospital Insurance)* and with carriers to administer Part B (Supplementary Medical Insurance). To measure these contractors' performance in terms of the volume of claims, productivity, processing lags, billing lags and administrative costs, the Health Insurance Statistics Branch of the Bureau of Health Insurance** uses some of the data obtained from the Master Records as well as information supplied directly by the intermediaries and carriers.

For intermediary assessment, the Utilization Record is used to generate statistics on the admission and billing process. The admission notices are used to measure the volume of admissions to hospitals by month of admission and the number and rate of duplicate and erroneous notices transmitted. The Utilization Record provides data on the time lag between the patient's discharge and preparation of the bill by the medical facility and between receipt of the bill by the intermediary and the intermediary's determination as to whether the bill should be paid in full or in part. These processing time statistics are available for each intermediary and provider.

In addition to the admission notices and the bills submitted by the providers through the intermediaries to SSA, each intermediary prepares a monthly and quarterly operational report. SSA uses these reports to assess the intermediary's workload. They show the number of bills received and paid for the month, the number denied because the

* Intermediaries are also involved in administration of some Part B related benefits that are covered under Part A.

** Until July 1975, this branch was in the Office of Research and Statistics.

services were not covered or the person had exhausted his benefits, the number of bills that required additional investigation because they were incomplete or inconsistent, the number of bills pending at the end of the month, and the number of those bills that have been pending for over 30 days. These intermediary statistics are reported separately for bills for inpatient hospital, outpatient hospital, extended care, or home health care services. Processing time and volume data are also submitted by the carriers for Part B requests for payment, but, for the carriers, these statistics are grouped according to whether the bills were assigned or non-assigned.* Contractors provide quarterly data on claims appealed by beneficiaries or suppliers of services and also report on other aspects of their administrative activity such as detection and recovery of overpayments.

Using this data and the bills submitted to SSA for intermediary administrative costs, the Health Insurance Statistics Branch prepares a series of reports that aid in the assessment of the performance of individual intermediaries.** These reports include a monthly report on the workload of each intermediary; a quarterly report on the health insurance bill processing time by the provider, the intermediary, and SSA; a monthly report of the number of errors submitted by the intermediary which have been picked up by the Bureau of Data Processing editing process; and a quarterly report on the number of appeals handled by each intermediary. The SSA Contract Financial Management Branch in BHI generates periodic reports on the amount expended by SSA for the intermediary's administrative costs. In addition, the Contractor Operations Branch of BHI produces a quarterly provider audit activity report giving the number of full scope and limited scope audits done by each intermediary, the timeliness of said audits and the number of desk review audits.

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* "Assignment" means that the physician has agreed to accept the Medicare payment amount as payment in full from the beneficiary (see page 7 above).

** Similar reports are also prepared for individual carriers.

These statistics are used by the Regional Office staff of BHI to supplement their on-site reviews of the intermediaries by providing national statistics against which local statistics can be compared. However, each intermediary's monthly report is submitted directly to the Regional Office to facilitate immediate handling of pressing problems. The management support statistics and Regional Office on-site reviews of the intermediaries form the basis of the Annual Contractor Evaluation Reports (ACERs) that are written by the Regional Offices assessing the performance of each intermediary and carrier. The ACERs are submitted to BHI's Contract Operations Division.

Section 4: Monitoring Utilization - MADOC and MEDPAR

MADOC: Medicare Analysis of Days of Care. The Medicare Analysis of Days of Care, generally referred to as MADOC, was a series of reports prepared by the Office of Research and Statistics (ORS) from 1969-1972, which presented comparative data on the lengths of stay of Medicare patients discharged from short-stay hospitals. The purpose of MADOC was to help hospitals and and intermediaries assess utilization patterns as measured by comparing actual lengths of stay in hospitals in a geographic area with an "expected" average length of stay generated from a computerized multiple regression model. The expected length of stay was a figure which represented the pooled experiences of all hospitals in that area. Hospitals with unusual utilization patterns as measured by the difference between actual and estimated length of stay could then be identified. The estimate for each hospital reflected its patient characteristics, the characteristics of the facility, the types of illness of the patients, and the treatment provided them.

Data on actual length of stay, on diagnoses and surgical procedures, and on services provided were derived from the billing forms submitted by hospitals to SSA for each beneficiary admitted and discharged. As discussed in the section on the Utilization Record, a 20% sample of all billing forms

is coded for diagnosis and surgical procedures and used to generate both utilization statistics and MADOC reports. The MADOC data on hospital characteristics was derived from the Provider of Service file (see Part II) which contains the information submitted by hospitals as part of their certification. The demographic characteristics of the Medicare beneficiaries discharged by each hospital were obtained from the SSA Master Eligibility Record (see Part II).

The hospitals were grouped for purposes of analysis into 275 geographic areas roughly equivalent to the Hill-Burton hospital service areas and made up of contiguous counties or parts of counties within each state. Some modifications were made in the Hill-Burton areas in order to make the areas conform to an area serviced by an individual fiscal intermediary. Each area had a minimum of 5 hospitals and 1000 beds and a maximum of 50 hospitals.

The MADOC reports used four general classes of independent variables to derive the regression equation for computation of the "expected" length of stay. Hospital variables included the number of certified adult beds, the number of active staff members, the number of facilities and services, the number of resident training programs, the presence of medical school affiliation, the type of hospital (general or specialty), and the type of ownership. The patient variables were age, sex, and discharge status (live or dead). Illness variables included the 29 most frequent Medicare discharge diagnoses (eight of these 29 discharge diagnoses are cases where surgery was performed during hospitalization), 19 clusters of diagnoses (not included in the 29 cited above) which are grouped by their average length of stay under Medicare, the presence of multiple diagnoses, the presence of both multiple diagnoses and a surgical procedure, and the presence of a selected discharge diagnosis with an additional diagnosis. The treatment variables included presence of surgery, pints of blood administered, charges in dollars for intensive care, operating room, radiology, and laboratory services, and average daily charges for pharmacy and supplies. Using these variables, the regression equation produced an

estimated length of stay which could be compared to the hospital's actual length of stay.

The comparison of estimated to actual length of stay was accomplished through a series of 6 tables which were generated for each of the 275 hospital service areas. These 6 tables which covered a 6 month period constituted the MADOC report for that service area. It should be understood that while MADOC analyzed every Medicare hospital in the nation, MADOC reports were only generated for each service area and were not presented on a national basis.

The 6 MADOC tables listed each of the hospitals in the service area with at least five discharges for the 6 month reporting period. MADOC Table 1, the summary table, showed the number of discharges in the sample, the actual length of stay in days, the estimated length of stay in days, and monthly differences between average actual and estimated length of stay for each hospital. An asterisk was used to indicate those hospitals for which differences between actual versus estimated length of stay was statistically significant.

MADOC tables 2-6 provided statistical clues as to what might account for out-of-line lengths of stay in Table 1. Table 2 distributed the sample discharges, whose average was shown in Table 1, by the number of days in the hospital stay. Table 3 showed average actual lengths of stay by hospital for the 10 diagnostic conditions reported most requently as requiring hospitalization among Medicare patients. The data were obtained by coding the discharge diagnosis according to the eighth revision of the International Classification of Diseases (ICDA), adapted for use in the United States in 1967. In Table 4 the sample discharges were distributed by day of week of hospital admission and in Table 5 the live discharges were distributed by day of week of discharge. Table 6 showed the number of sample discharges with and without surgery and the corresponding average actual lengths of stay for each hospital. Data on the average length of preoperative and post-operative actual stay for surgical cases was also shown.

When the MADOC system was initiated in 1969, it was intended that the series of 6 tables would be generated for each hospital service area every 6 months. The first MADOC report covered the period of July 1969 - December 1969. Subsequent reports covered January - June 1970; July - December 1970; and January - June 1972. No reports were produced for 1971 and no reports have been generated since June 1972. Severe processing and computer problems have been cited as the reason for the irregular basis of MADOC reports. Some claim that the failure to produce the MADOC reports on a regular basis has undermined the system's original function of monitoring utilization patterns among hospitals because it makes it impossible to use MADOC to compare each hospital's current experience to that of all hospitals in its area for the preceding year. However, ORS staff responsible for MADOC maintain that the failure to generate timely information is not really a significant problem, because MADOC information is still relevant even if it is old. They claim the critics of MADOC's timeliness ignore the fact that problems of misutilization that result in a hospital being tagged exist over time so that the fact that the data is a year or two old does not mean that the hospital doesn't still have the same problems. In fact, when MADOC reports were generated, the same hospitals were tagged in almost every report.

Some ORS staff feel that the major problem underlying MADOC was the failure of ORS to do a good job in explaining to the hospitals and BHI how the report works. As a result the BHI staff did not use the MADOC reports administratively and no action was taken against those providers tagged as aberrant by MADOC. Interviews with staff of the Bureau of Health Insurance revealed a general lack of awareness of the potential uses of the MADOC system. It seems that the potential of MADOC as an alert system for hospital misutilization was not realized because of lack of understanding of its uses and failure to implement administrative procedures to validate predictions and impose sanctions on out-of-line providers.

Medicare Provider Analysis and Review (MEDPAR). The Medicare Provider and Review (MEDPAR) report is a series of semiannual reports presenting comparative data on lengths of stay of Medicare patients discharged from short-stay hospitals participating in the Medicare program. For purposes of the MEDPAR report series each short-stay hospital is grouped into one of the 203 geographic areas designated as PSRO service areas. The series was initiated in May, 1976 to replace the MADOC series and assist administrators in implementing the utilization review provisions of the 1972 amendments to the Social Security Act (P.L. 92-603). The first report, MEDPAR-1, contains data for Medicare discharges during July 1973 through June 1974.

MEDPAR is intended to provide summary statistical data on length of stay experience in each hospital for every PSRO area. An estimated average length of stay is computed for each hospital participating in Medicare based on the hospital's patient characteristics, the characteristics of the facility, the illnesses of the patients, and the treatment rendered. This estimated length of stay is computed by using the multiple regression analysis described in the MADOC section. By comparing this estimate with the hospital's average actual length of stay, hospitals with unusual utilization patterns can be identified. A probability index for each hospital measures the magnitude of this differnce. The accumulation of this information over time will permit trend analysis of the length of stay experience of a particular hospital.

The MEDPAR reports are based on data from the Medicare program basic records. The Part A Utilization record and resultant 20% sample are used for data on actual length of stay, on diagnoses and surgical procedures, and on services rendered. The hospital's characteristics are derived from the Provider-of-Service record while the demographic characteristics of the beneficiaries discharged by each hospital are obtained from the Master Eligibility Record.

A series of 18 tables comprises the MEDPAR report series for each PSRO area. A probability index in Table 1 provides a key for identifying

hospitals with potential utilization problems; the remaining 17 tables aid in determining the source of the problem. Table 1 shows the number of discharges in the sample, the actual length of stay in days, the estimated length of stay in days, the probability index for obtaining the difference between estimated and actual length of stay by chance alone, and the monthly differences between average actual and estimated length of stay for each hospital in the PSRO area. Table 2 distributes the "live" discharges sample and Table 3 the "dead" discharges sample by the number of days in the hospital stay.

The number of sample discharges by diagnosis for 15 selected diagnostic conditions to be used in PSRO evaluations are shown in Table 4 with the average length of stay for these sample discharges shown in Table 5. In Table 6, the sample discharges for each hospital are distributed by day of the week of hospital admission, while in Table 7 the live discharges are distributed by day of week of discharge.

Tables 8, 9 and 10 respectively show the number of discharges with and without surgery, the distribution of sample discharges by indication of surgery and number of diagnoses, and the average length of stay associated with the sample discharges distributed by surgery and number of diagnoses.

Table 11 distributes sample discharges by age while Table 12 shows the average length of stay associated with age distribution. Similarly, Table 13 distributes discharges by sex and race and Table 14 depicts the length of stay associated with this distribution. Table 15 shows the average total charge per sample discharge and average total charge per day, while Table 16 lists selected characteristics of each hospital.

Tables 17 and 18 focus on the PSRO area as a whole instead of on individual hospitals. Table 17 lists for selected primary discharge diagnoses the number of sample discharges, average length of stay, standard deviation and selected percentiles. Table 18 does the same for selected surgical procedures.

The key factor in flagging hospitals with potential inappropriate utilization patterns is the size of the probability index in Table 1. This index shows the difference between a hospital's average actual and estimated length of stay. The smaller the index, the more likely the existence of unusual utilization patterns. If a hospital has a small index, the data in MEDPAR tables 2-18 may be helpful in identifying which, if any, of its practices may be contributing to the difference.

MEDPAR, in the opinion of ORS staff, represents the first time the Master Eligibility Record, Provider of Service Record, and Utilization Record have been linked in a timely fashion. As previously discussed, the MADOC report suffered from the failure to generate the series using current data. ORS has now improved their computer accessing capablity which allows them to have access to all calendar year 1975 claims data by July 1976. As a result, they plan to release the second MEDPAR report on calendar year 1975 in January 1977. ORS staff believe that the one-year turnaround time from the end of the calendar year is the fastest processing schedule possible.

Given the timeliness of MEDPAR data, ORS hopes that PRSO areas will use the series to get an immediate overview of the utilization patterns in the area's hospitals. In a few years, as the PSROs build up their internal capabilities and produce more specific utilization data, the function of MEDPAR may shift from a mechanism to aid PSROs to the device for monitoring and comparing the PSROs themselves.

Section 5: Reviewing Program Experience - the Health Insurance Statistics Series and Related Reports

The Annual Health Insurance Statistics Series is prepared by the Office of Research and Statistics (ORS) from data contained in the master records or obtained from the Current Medicare Survey. The series is published in several sections:

- Section 1, Summary
- Section 2, Enrollment
- Section 3, Participating Providers
- Section 4, Short Stay Hospital Utilization

Section 3 is divided into four subsections: Participating Hospitals; Participating Home Health Agencies; Participating Independent Laboratories; and Participating Extended Health Facilities. In addition, ORS publishes the Health Insurance Notes (HI Notes) series and the Current Medicare Survey Notes (CMS Notes) to provide current quick-release data from the Medicare program. Analyses of medical care expenditures, prices, and utilization are also presented in articles in the Social Security Bulletin, a monthly publication.

In the annual series, the Summary Report provides an analysis of the utilization of services under Medicare and the reimbursement by persons for a given year of program operation. Based on the Utilization Record, the data used in this report are derived from a 5% sample of the bills received by SSA. This 5% sample is a subsample of the 20% sample of Inpatient Hospital claims for which diagnosis and surgical procedures have been coded (see Utilization Record section in Part II above) and counts are multiplied by 20 to estimate the total number of persons who used benefits under the program. In addition to the analysis of type of benefit reimbursed, use of reimbursed services, reimbursement per person served, distribution of amounts reimbursed, and persons who used no reimbursed services, the summary report also contains a variety of tables which summarize the types of services provided and amount of reimbursement by region, division, and state, and by age and sex of the enrollee.

As part of section 1 Summary Report Series, separate reports entitled Reimbursement by State and County and Geographic Index of Reimbursement are also prepared. These reports are derived from 100% data instead of a sample. The former provides information on the number of persons enrolled and the amount reimbursed for Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) in each county. The latter provides tables which

give the geographic index, age-sex index, and reimbursement per person enrolled by county and state for both hospital insurance and supplementary medical insurance. The geographical index is a derived ratio for each county that is based on the reimbursement data standardized for age and sex distribution of the county population. This ratio provides a comparison of per capita county reimbursements under Medicare with the national average.

Section 2, Enrollment, is derived from the Master Eligibility Record and offers an analysis of the characteristics of the Part A and Part B enrolled population. Enrollment figures are based on 100% data and broken down by the type of coverage, age, sex, region, division, and state of residence, residence in a metropolitan versus non-metropolitan area, and SMSA area.

Section 3, Participating Providers, is prepared from the Provider-of-Service record and presents 100% data on selected characteristics of the hospitals (and other facilities in separate documents) that meet the conditions for participation in the Medicare program. The types of hospital participating in Medicare and the level of compliance with the conditions for participation are assessed. Tables are generated giving the number of hospitals, beds, and beds per 1000 enrolled population by type of hospital for each region, division, and state and the United States as a whole; the number of hospitals by control, type of hospital, and bed size per state; facilities and services by type of hospital, bed size, and number of hospitals reporting each service; number of hospitals, beds, and percent distribution by type of hospital and affiliation by state; etc. From this report, the general characteristics of Medicare - participating hospitals can be obtained for each state. Individual hospitals are not identified.

The Section 4 series offers an analysis of medical services utilization under Medicare. The Short-Stay Hospital Utilization Report is derived from the Utilization Record and is based on the bills for inpatient services submitted by the hospitals for a 20% sample of the insured population.

Information from the billing form is matched to the Master Eligibility Record which includes demographic information about each person eligible for Medicare. The utilization data from the bills are also matched to the Provider-of-Service Record to permit analysis of utilization trends linked to hospital characteristics. Using this combination of billing data, demographic characteristics of beneficiaries and characteristics of hospitals, a variety of utilization variables are analyzed including: the number and rate of short-term hospital discharges, the average length of stay, days of care, hospital charges and amounts reimbursed, hospital charges not reimbursible by Medicare, and the number of persons with one or more discharges. An assessment is made of utilization with or without surgery. These variables are analyzed by region, division, and state; by age, and sex of the beneficiaries; by type of hospital control and bed size; and by discharge status (alive or dead) and detailed length of stay; by type of training program, JCAH accreditation, and bed size of hospital; and by month of admission. This report series therefore provides a comprehensive overview of Medicare utilization in short-stay hospitals. As in the series on participating hospitals, individual hospitals are not identified in the reports.

In addition to the annual statistical report series described above, as of June 1976, the Office of Research and Statistics has published data on the length of stay by diagnosis and surgical procedure for 1969, 1970, and 1971. These reports are based on the 20% sample of Medicare beneficiaries that is coded for diagnosis and surgical procedures derived from the Utilization and Master Eligibility records. This is the same file that was used for the MADOC report and is used for MEDPAR.* The sample counts are multiplied by five to give an estimate of the total number of discharges. To aid in studying hospital utilization patterns, this report series

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* MEDOC/MEDPAR present utilization data by individual facility to enable monitoring of utilization patterns at the micro level; the annual series presents aggregate data summarized by region to allow macro level analysis of program utilization.

presents national and regional data for a given year on the number of Medicare beneficiary discharges from short-stay hospitals, the mean and median length of stay and the percentile distribution of days of care for elected diagnoses and surgical procedures. For each diagnosis, data are presented for selected discharge characteristics, such as age, presence of secondary or complicating conditions, and whether or not surgery was performed. For surgical procedures, data are presented by age and the presence of secondary or complicating conditions.

The reports described in Section 5 above are indicative of some of the types of analysis possible from the Medicare record system, but serve only to scratch the surface of possible reports. For example, ORS is now preparing medical reimbursement history files for a 5% sample of beneficiaries. This file will bring together related data from all Medicare bills for the 5% sample to form one record. This composite file, begun in 1974, will be the source for annual "person" summary statistics.

Section 6: Discussion

The reports and analyses described in this section represent some of the ways the Medicare basic records are now used. As discussed in the descriptions of the various reports, some are generated for administrative purposes and others for research and evaluation. Each of these reports is generated to aid an SSA component or contractor, such as the fiscal intermediaries, in performing their Medicare responsibilities. The users of these reports were interviewed and the discussion that follows is based on their comments regarding the usefulness and quality of the reports they use. In some cases, individuals interviewed also commented on the reasons why they did not use or rely on a given report.

The Provider Statistical and Reimbursement Report (PS&R report), was designed primarily for use by the fiscal intermediaries in settling the provider cost reports. As discussed in the PS&R section, many intermediaries are now capable of generating their own PS&R reports that are

substantially more up-to-date and accurate than the SSA reports. This is because the intermediaries receive the billing information directly from the providers which eliminates the lengthy delays involved in transferring information to central SSA files in Baltimore. Because SSA's PS&R reports are out-of-date before they are even produced, BHI recommended that the PS&R report at SSA be eliminated and the responsibility be given to intermediaries. As noted, this was done for all but 40 intermediaries. It is of interest to note that when Medicare began in 1966, SSA refused to allow the intermediaries to generate their own PS&R reports and required that that function be done centrally at SSA. By 1975, SSA had totally reversed its position and was urging the intermediaries to develop their own PS&R systems.

The Provider Monitor Listing is generated from the same data as the PS&R report and is therefore regarded as an inaccurate reflection of hospital charges by those SSA staff members who are critical of the PS&R report. However, the BHI Program Integrity Staff that is responsible for provider fraud and abuse feels that the Provider Monitor Listing is useful to them as an alert system for out-of-line provider charges. They claim that for their needs, the listing does not have to contain the most up-to-date information because they are most interested in general trends. However, it should be noted that while the listing ranks providers according to level of charges for given services, only bed size, region of location, and type of ownership are taken into account when grouping the hospitals in the listing. No attempt is made to rank providers by complexity of cases, teaching versus non-teaching, or urban-rural location.

The Management Support Statistics are generally viewed as an accurate assessment of the billing volume and processing time of the intermediaries and carriers. These statistics are used by the Regional Offices as one means of assessing the contractors' performances. The section responsible for preparing the management support statistics has recently been transferred from the Office of Research and Statistics to the Bureau of Health Insurance. It was felt that this move would permit them to gain a

better understanding of BHI's operational needs and therefore assist them in improving the usefulness of their service statistics.

MADOC and MEDPAR Utilization Reports. As discussed in the preceding section, the MADOC report series did not realize its potential as an alert system for hospital misutilization for a variety of reasons including lack of understanding by potential users of the uses of MADOC, failure to generate the MADOC reports in a timely fashion, and failure to implement administrative procedures to validate MADOC predictions and impose sanctions on out-of-line providers. The MEDPAR report series, MADOC's replacement, seemingly has overcome the timeliness problems of MADOC through the development of direct computer accessing from ORS to the Office of Data Development (ODD). It is still too early to predict whether MEDPAR will succumb to other pitfalls that stymied the effective use of MADOC, but there are hopeful signs that it will not.

First, MADOC was implemented in 1969 for use by the BHI regional offices in monitoring the utilization patterns of hospitals in their areas. However, in 1969 the climate for utilization review activities was lax, thus creating little, if any, pressure on the regional offices to use MADOC to monitor hospitals' utilization performance. But, in 1972 in P.L. 92-603, Congress strengthed the utilization review activities of the Social Security Act by creating PSROs and mandating that utilization reviews be implemented as a condition for receipt of federal funds for Medicare and Medicaid patients. Given this new climate and the existence of an agency, the PSRO, with a specific mandate to monitor utilization, one can speculate that the MEDPAR report will not be set aside as the MADOC report was, but instead be viewed as a useful tool to begin to meet the review activities required in P.L. 92-603.

Second, there are positive signs that ORS will take a more active role in educating potential users to the significance of the MEDPAR data and its possibilities as a utilization monitoring device. A presentation on MEDPAR was made to the PSRO National Council on March 8th, 1976. Other

meetings of top-level staff in DHEW including the Directors of the National Center for Health Statistics, Bureau of Health Planning and Resource Development, and the Bureau of Quality Assurance have been held to review the report and discuss its potentialities. The response has thus far been reported as enthusiastic.

The Health Insurance Statistics series is generated by the Office of Research and Statistics for use by SSA, Congress, other DHEW components and the public in assessing the Medicare experience, and developing future policies. When Medicare was first implemented, it was intended that these reports would be produced annually and would therefore provide current information on Medicare program operations. However, this objective has not been realized. The utilization in short-term hospitals report was published for 1967, but, as of June 1976, additional reports had not been generated. ORS plans to publish the 1968-1970 reports by the end of 1976 and the 1971 and 1972 reports in early 1977. The long delays are attributed to a variety of factors including lack of adequate personnel, changes in the record form for the health insurance system that required redesign of the computer program, and use of three different systems for computer processing. In addition, ORS claims it is given a low priority for access to the computer that stems from the attitude that SSA is primarily in the business of administering a program and paying bills. Since statistics are viewed as a byproduct of the administrative process, processing for statistical reports is regarded as secondary in importance and is often not allocated the staff and computer resources necessary for timely reporting.

PART IV. HOSPITAL COST DATA

Hospitals are reimbursed for services provided to Medicare beneficiaries under Part A on the basis of reasonable costs. In order to determine its level of reimbursement, each hospital must submit an annual Medicare Cost Report to the designated fiscal intermediary. The intermediaries forward the cost reports to SSA after reimbursement determinations have been made. The annual Medicare Cost Report together with its administrative and research uses are reviewed in the three sections to follow. In the fourth section, a new undertaking of SSA's Office of Research and Statistics, the Hospital Cost Monitoring Project, designed to supplement the data available from the cost reports, is described.

Section 1: The Medicare Cost Report

The Medicare principles of reimbursement, as determined by the Social Security Act and the regulations promulgated under that Act, define the costs of a hospital that are allowable for reimbursement for services rendered to Medicare beneficiaries under Part A.* The cost report, a package of approximately 40 pages of worksheets, is the basis for this retrospective determination.

The provider is required to furnish all information requested in the cost report by virtue of the authority granted to the Secretary of DHEW under Section 1814(b)(1) of the Social Security Act (42 USC § 1395f). If the provider does not provide all or any of the requested information, the cost report can be considered incomplete and not acceptable for claiming reimbursement under Medicare.

The Medicare regulations and the worksheets in the cost report related to these regulations establish the means by which the provider is:

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* The Medicare principles of reimbursement, methods of calculating reimbursable costs, and payment process are described more extensively in Appendix B of this report.

- to separate costs allowable under Medicare from non-allowable costs
- to allocate the costs of non-revenue producing centers to the revenue producing centers, and under the step-down method, to each other (cost finding)
- to determine the share of total costs which are attributable to Medicare patients and therefore payable from Medicare (cost apportionment)

The cost of Part B services provided in the hospital must also be separated from service costs covered under Part A. A specific reporting form is provided for each of the determinations or adjustments required in the regulations. The worksheets for hospitals cover the following areas:*

- statistical data
- reclassification of and adjustment of trial balance of expenses
- adjustments to expenses
- administrative and general expense
- dietary expense
- medical-surgical expense
- laboratory expense
- depreciation
- statement of costs of services to related organizations
- statement of compensation to owners
- statement of compensation paid to administrators other than owners
- cost allocation - statistical base
- cost allocation - general service costs
- cost apportionment - dietary
- departmental cost distribution - statistical bases

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* The cost reporting form titles are those used on the old cost report package for Medicare hospitals for reporting periods beginning before July 1, 1975. The form titles were the same for hospitals with less than 100 beds and hospitals with 100 beds or more.

- departmental cost distribution - patient care costs
- computation of inpatient routine service cost
- calculation of reimbursement - settlement - inpatient service
- calculation of reimbursement settlement - Title XVIII, Part B
- optional calculation of percentage of bad debts for outpatient services applicable to professional component of hospital-based physicians - combined billing
- computation of inpatient ancillary services covered by Part B
- apportionment of remuneration for professional services rendered by hospital based physicians applicable to the health care programs
- summary of remunerations for professional services rendered by hospital based physicians applicable to the health care programs.
- cost apportionment of ambulance services rendered by the provider
- calculation of reimbursement settlement for interns and residents not under approved teaching program - supplementary cost form
- cost per unit of service (eliminated from later forms)
- balance sheet for computation of equity capital
- computation of return on equity capital for proprietary providers
- apportionment of allowable return on equity capital of proprietary providers

The cost reporting forms are submitted annually by each of the 6800 hospitals certified for reimbursement under Medicare.* As the Medicare program has evolved and reimbursement policies have been altered, the cost report package has been revised to reflect these changes. For cost reporting periods prior to June 30, 1975, all hospitals were required to complete a series of forms supplying intermediaries with the information necessary to compute reimbursement of reasonable costs for the accounting year. Collectively, these forms constituted the provider's annual cost report.

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* The chart in Appendix C provides a more detailed description of the contents of the cost report package outlined above.

This cost report package, hereafter referred to as the "old cost report", consisted of two basic forms and a series of required supplements:

Basic Forms	SSA 1562	Reimbursable Cost on Departmental RCC Method or Combination Method computed with cost finding
	SSA 1563	Hospital Statement of Reimbursable Costs
Supplementary Forms	SSA 1992	Modified Hospital Cost Reimbursement forms (to reflect 1967 amendments to Social Security Act, instituted 12/69 and used by free-standing hospitals; hospitals with SNFs use SSA-9554 instead)
	SSA 2570	Modifications to Hospital, Hospital Extended Care Facility Complex, and Extended Care Facility Statement of Reimbursable Cost (to reflect 1972 Amendments to Social Security Act, instituted 12/72)
	SSA 2781	Modification of Medicare Cost Reporting Forms to provide for Section 201 (extends Medicare to the Disabled) of the 1972 Amendments to the Social Security Act (instituted 11/74)
	SSA 2781A	Modification of Medicare Cost Reporting Forms to provide for Section 299 (extends Medicare coverage of end-stage renal disease services) of the 1972 Amendments (instituted 11/74)
	SSA 9553	Hospitals with a separately certified Extended Care Facility and/or Home Health Agency Computing Reimbursable Cost on the Departmental RCCAC or Combination Method with cost finding (instituted 12/70)
	SSA 9554	Hospital, Hospital-Based Extended Care Facility and/or Home Health Agency Statement of Reimbursable Costs (only used by hospitals with an attached SNF)

Using these forms, the hospital completed the various worksheets required to reclassify the trial balances and separate allowable from non-allowable costs, allocate the costs of non-revenue producing centers to revenue producing centers (cost finding), determine the proportion of

departmental cost attributable to Medicare beneficiaries (cost apportionment) and finally calculate the amount of reimbursement due to the provider from Medicare. The general principles of reimbursement and methods for cost apportionment and cost-finding are reviewed in Appendix B. The cost report is designed to elicit the information necessary to make a reasonable cost determination based on these principles. The specific data items requested are enumerated in the old cost report section of the table in Appendix C.

For cost reporting periods commencing on or after June 30, 1975, hospitals with 100 or more beds were required to use a new cost report. The new form, SSA 2552, or "Hospital and Hospital-Skilled Nursing Home Facility Complex Statement of Reimbursable Cost, " is basically a consolidation of the series of temporary forms issued to supplement SSA 1562 and SSA 1563 in response to changes in the cost determination requirements in the 1972 Amendments to the Social Security Act (PL 92-603). The new cost report, SSA 2552, supercedes all previous cost report forms (SSA 1562, 1563, 1992, 2570, 2781, and 2781A) for hospitals and hospital-SNF complexes with 100 or more beds.*

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* The new cost report section of the table in Appendix C describes the data items in SSA 2552 and, where appropriate, comments on the differences between SSA 2552 and the old cost reports. As discussed in Appendix B of this report, hospitals with 100 beds or more compute their reasonable costs of providing services by using the departmental method of cost apportionment with step-down or a more sophisticated method of cost finding and hospitals with under 100 beds currently use the combination method of cost apportionment and the simplified method of cost finding. Because of the different methods employed, the cost report package for hospitals with under 100 beds includes most of the forms outlined above, but the format and information requested in forms of the same title may differ slightly from the package for hospitals with 100 or more beds. In some cases, hospitals using the combination method are instructed to only complete part of a form or are given a substitute form requiring less detail and designed specifically for use with simplified cost finding or the combination method of cost apportionment.

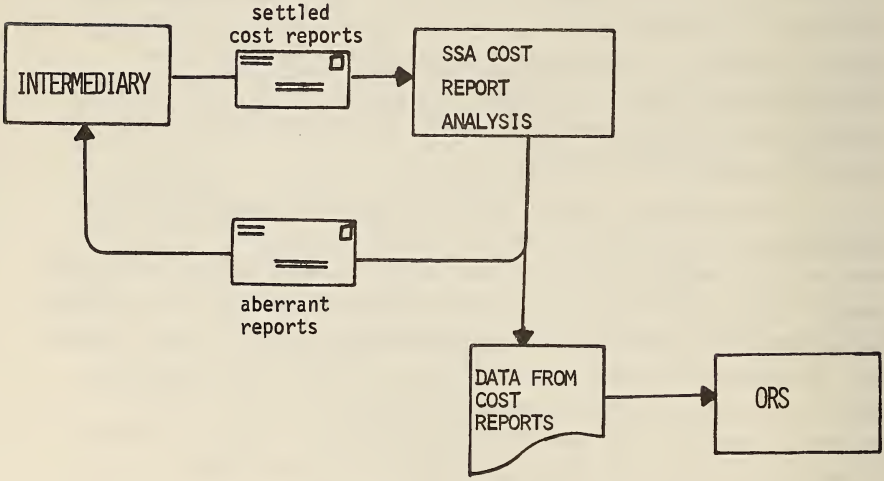
Section 2: Processing and Using the Cost Reports

After the intermediary has arrived at a final reimbursement settlement with the provider, a process that may take several years, copies of the cost reports are sent to the Cost Analysis Branch of the Bureau of Health Insurance (see Exhibit 7) in the central SSA offices in Baltimore. Until July 1975 this branch was in BHI's Division of Provider Reimbursement and Accounting Policy (DPRAP), but it is located now in the BHI Division of Contract Operations. This branch is responsible for abstracting and preparing the cost reports for computer processing and for formulating and implementing an ongoing statistical analysis of reported provider cost, utilization, and statistical data.

The Cost Analysis Branch receives all settled cost reports and stores the hard copies of these reports in files for at least three years. From these cost reports, selected items are to be abstracted for coding onto computer tapes. These items are primarily those reported in the cost report package forms for statistical data, computation of inpatient routine service cost, calculation of reimbursement settlement, remuneration of hospital-based physicians, and balance sheet for computation of equity capital. From these statistics, the total reimbursable cost for Medicare services in the hospital, total outpatient expenses, total patient days, proportion of patient days attributable to Medicare, and the cost for selected cost centers can be determined. The abstracted cost reports are then to be sent to the Bureau of Data Processing for keypunching and coding. Once on computer tapes, the cost report data would be available for use by both the Bureau of Health Insurance (BHI) and the Office of Research and Statistics (ORS).

In theory, once the cost report data are computerized, cost reports with aberrant conditions, such as extremely high cost for hospital-based physicians or unusual research costs, are identified. These reports are then to be analyzed by the Cost Analysis Branch staff and returned to the intermediary for review of questionable areas.

EXHIBIT 7: PROVIDER COST REPORT ANALYSIS



SOURCE: U.S. Department of Health, Education, and Welfare, Social Security Administration, Health Insurance System: A Narrative and Pictorial Description, February, 1975.

In practice, it seems that the Cost Analysis Branch, for a variety of reasons, has been unable to perform these functions for which it was designed. Several major deficiencies of the cost analysis system were cited by a DHEW Audit Agency team in a report based on a review of the cost analysis system through June 1973. The report, audit control number 13-50001, was given to the Director of the Bureau of Health Insurance and stated:

> Our review showed that the cost analysis system, as administered by the Provider Cost Analysis Branch (PCAB), has been unable to (1) supply current, statistically sound data for responding to specific requests for cost information, (2) evaluate the program's share of total health care costs, (3) generate recurring reports to the Commissioner or Congress regarding program costs, and (4) establish standards for identifying out-of-line provider costs in need of further investigation. Operating problems have plagued BHI's cost analysis system almost from its inception. In February 1971 PCAB initiated a status report on their operations and stated that their "...objectives had not been met to the degree originally envisioned because of various limiting factors." Major factors identified were the incompleteness of reported cost data for policy validation and program evaluation and delays in the receipt of provider cost reports which limited the usefulness of data developed from them. These limiting factors had not been corrected at the time of our review.

In response to criticism that cost report data are received and stored by the Cost Analysis Branch but not fed into the computer system, the Cost Analysis Branch cites problems with SSA's Bureau of Data Processing (BPD) and claims that BPD is uncooperative and thwarts their efforts to keypunch and code the data. As an example, the Cost Analysis Branch cited its new system for abstracting the cost reports which was implemented in March 1973. BPD was requested to transfer to the new system, but as of July 1975, BPD had not produced a single computer run from the cost reports submitted after March 1973. The last computer run was received by Cost Analysis in February 1974 and contained March 1973 data using the old

abstracting system. Cost report data for the remainder of 1973, 1974, and 1975 is not even on computer. Cost Analysis claims it is prevented from being able to fulfill its responsibilities because the needed data is in the computer or is computer ready, but BDP doesn't produce the print-outs. The Bureau of Data Processing contends that they promptly process all cost analysis data, and blames Cost Analysis for the delays. Other staff of BHI seem to fault both parties.

Some maintain, however, that even if there were no computer problems the cost analyses would still be out of date and irrelevant to their needs, since the cost reports are between two and five years old before they even reach the Cost Analysis Branch because intermediaries do not forward the cost reports until final settlement has been made. The long delays in receipt and computer processing of the cost reports reportedly prevent the cost report data from being prepared on a computer tape that can be linked to the basic record tapes. Thus, the cost report data is not integrated with the certification data or the billing data.

Several SSA staffers felt that many of the processing problems are partially due to requiring too much data that is of little use in the cost reports. They feel that the abstracting of all this "relatively useless" data creates lengthy delays in processing the cost reports and makes the useful data items in the cost reports out of date before they become available. There have been attempts to simplify the cost report which currently consists of 40 pages of worksheets. At one point, a six page draft cost report form was circulated within BHI for comment. When all the BHI administrative units had added the data items considered essential to perform their various functions, the cost report had once again swollen to a 40 page document.

BHI staff also claim that some of the cost analysis problems are exacerbated by ORS because ORS researchers want too many data items abstracted from the cost reports. The BHI staff expressing this opinion

maintain that ORS never uses some of the information abstracted from the cost reports and speculate that retrieval of cost report information could be more timely if ORS simplified the amount of data to be programmed. On the other hand, ORS staff complain that the balancing and editing process for cost reports creates additional delays because everything must be "accountant accurate" before programming. There is reported to be a two year backlog of almost 40,000 cost reports in BDP. As a result of these delays and problems in getting computer priority at BPD, which gives direct payment processes top priority, ORS has gone outside of SSA and contracted with the AHA to obtain hospital financial data and with a private firm for computer processing of this data for the Hospital Cost Monitoring Project.

In addition to these problems with the Cost Analysis Branch, the BHI Cost Reporting Policy section maintains that replacing and revising existing forms to assure that providers comply with changes in the Medicare statute and regulations is so time consuming that there is no time left to evaluate and simplify the form itself. They point out that the new cost report, SSA 2552, took four years to develop because they continually had to set the new report development aside to make modifications in existing forms to meet changing program policies.

However, assuming that despite many of the timeliness and processing problems, the cost reports do meet the annual reimbursement purposes for which they were designed, it can be asked whether they have any other practical use. One recent instance of such an attemped use of cost reports as a data source has been SSA's contract for the evaluation of the impact of prospective reimbursement systems. The study method called for comparison of hospital cost trends in a state with prospective reimbursement to matched control hospitals in states without it. Comments from evaluators using Medicare cost reports for just such purposes highlight some additional problems with using cost report data.

These evaluators, when interviewed, all cited poor statistics as

a major weakness in the cost report data. Their lengthy list of examples is reviewed elsewhere in this project's reports, but a few illustrative examples are provided here to acquaint the reader with the general problem. Meaningful comparisons of costs after allocation of indirect expenses were prevented by lack of uniformity in cost finding methods, the number of cost centers used, the ordering of cost centers for allocation, or the combinations of cost centers selected for use. A hospital not using the RCCAC apportionment method does not have to submit revenue data but only cost data in the cost report. Many hospitals leave portions of the statistical data on page one blank, fail to break statistics down according to medical-surgical services, do not report full time equivalent personnel by department, and in some cases do not even report the total number of paid versus non-paid employees. Some hospitals submitted their own forms for the SSA worksheets and in some cases turned in a form that became obsolete in 1969 in the 1973 cost report.

Section 3: ORS Sample Cost Report Analysis Project

In 1975, frustrated by their attempts to obtain usable cost report data from the Cost Analysis Branch, ORS secured copies of the annual cost reports of a sample of 1200 providers for fiscal years 1971, 1972 and 1973 directly from the fiscal intermediaries. Under a separate contract between ORS and Applied Management Sciences, Inc., the 3600 cost reports for the three years have been abstracted and processed independently of SSA's Bureau of Data Processing.

From this sample of cost reports ORS staff have been able for the first time to run simulations to see which hospitals will be affected and how by proposed legislative changes in reimbursement policies similar to those in the Medicare and Medicaid Administration and Reimbursement Reform Act proposed by Senator Herman Talmadge in March 1976. ORS also plans to use the sample data to run simulations of different grouping options under Section 223 of P.L. 92-603 (see Appendix B, page 127) and

to run regressions to see if explanations can be found for variations in cost per patient day for routine inpatient services and total costs. As part of the ORS Hospital Classification Study Group, these regressions should help find out what variables are related to hospital costs and what these variables do to effect cost differences between hospitals. Some of the variables to be used in the analysis include rural versus urban location and teaching versus non-teaching orientation.

ORS also has plans to try to integrate this cost report data with the data from the AHA survey and the MADOC/MEDPAR case mix index for hospitals. As noted earlier in the MADOC section, this case mix index is based on the 20 percent sample of claims data coded for diagnosis and surgical procedures. This 20 percent sample of claims represents about 30 percent of all inpatient hospital days in the United States.

ORS intends as well to use the sample cost report data to conduct an inflation study on the percentage changes in costs in hospitals for each year in the three year sample. Total and routine inpatient costs and rates of change would be assessed. This research would be undertaken to try to develop incentives for hospitals to contain costs. If factors that seem to encourage hospitals to have lower costs can be identified, the Medicare program could design the reimbursement formula and related grouping schemes to take these factors and their effect on hospital cost increases into account.

Despite the significant progress in using the cost reports for analysis and research purposes, ORS staff point out that the sample cost report data are still far from ideal. When ORS ran simulations on the 1973 data, only 803 of the 1200 cost reports could be analyzed. The extensive non-reporting of items rendered a third of the cost reports useless.

The quality of the reported data varied among the different types of items on the cost report forms. ORS found that staffing levels and reporting of costs by hospital department were almost universally weak.

Similar findings were reported by the prospective reimbursement experiment evaluators. One non-SSA researcher claims that in a sample of 400 cost reports, almost 200 of them were submitted to SSA without reporting the total salaries or the total number of employees. Moreover, as previously noted, Schedule D of the old cost report package, the only form requesting data on the number of operations and procedures performed, was frequently not filled out by the hospitals since the data was not necessary for the reimbursement calculations. This schedule was eliminated in the new cost package. ORS now hopes to be able to obtain this type of information through the survey questionnaire for its Hospital Cost Monitoring Project.

Section 4: Hospital Cost Monitoring Project

The Hospital Cost Monitoring Project is a new endeavor of the Office of Research and Statistics (ORS) that is designed to provide SSA with monthly estimates by state of hospital costs and revenues, ancillary services utilization, the price of goods and services purchased by the hospital, and the prices of the medical goods and services provided by the hospital. These statewide estimates of hospital input and output prices will be used to supplement and refine the national CPI estimates computed by the Bureau of Labor Statistics on the basis of 300 hospitals that are all located in SMSAs.

The Hospital Monitoring Project is an expansion of the American Hospital Association's monthly survey of a panel of 1000 hospitals that is used as the basis for the "Hospital Indicators" section of the AHA's journal: Hospitals. The purpose of the AHA's voluntary panel is to provide current information on utilization and occupancy trends in hospitals as well as trends in their financial position. The questionnaire used in this survey is reproduced as Exhibit 8.

In October 1975, ORS entered into a contract (#600-75-0208) with the AHA to expand this panel to 2000 of the nation's 7100 hospitals, and to

EXHIBIT 8: QUESTIONNAIRE FOR CURRENT AHA NATIONAL HOSPITAL PANEL

NATIONAL HOSPITAL PANEL SURVEY

American Hospital Association

HOSPITAL WORK COPY

DECEMBER 1974

A. BEDS AND BASSINETS

1. Adult and pediatric bed capacity (set up and staffed for use)
2. Newborn bed capacity (set up and staffed for use)

B. UTILIZATION

1. Inpatient (adult and pediatric)
   a. Number of adult and pediatric admissions
   b. Total adult and pediatric inpatient days
2. Inpatient (newborn)
   a. Total births (exclude fetal deaths)
   b. Total newborn days
3. Outpatient Visits
   a. Emergency
   b. Clinic
   c. Other (referred patients)
   d. Total outpatient visits
4. Total surgical operations (in operating room)

C. FINANCES (omit cents, round to the nearest dollar)

1. Revenue
   a. Net inpatient revenue .00
   b. Net outpatient revenue .00
   c. Total net revenue from patients .00
   d. Other net revenue .00
   e. Total net revenue .00
2. Expenses
   a. Payroll (exclude employee benefits, professional fees and wages paid to interns, residents, and other trainees) .00
   b. Employee benefits (include FICA, unemployment comp., etc.) .00
   c. Depreciation expense .00
   d. Interest expense .00
   e. Other expense .00
   f. Total expense (a+b+c+d+e) .00
3. Current Assets (all *nonrestricted* funds — as of December 31, 1974)
   a. Cash (including cash imprest funds) .00
   b. Temporary investments .00
   c. Accounts receivable (less allowance for uncollected debts) .00
   d. Other current assets (include prepaid expenses, inventory, notes receivable, due from other funds, etc.) .00
   e. Total current assets (a+b+c+d) .00
4. Current Liabilities (all *nonrestricted* funds — as of December 31, 1974)
   a. Accounts payable .00
   b. Notes payable .00
   c. Other current liabilities (include salaries, wages, fees payable, deferred income, due to other funds, etc.) .00
   d. Total current liabilities (a+b+c) .00

D. PERSONNEL

1. Number of regularly employed personnel, excluding trainees, private duty nurses and volunteers
   a. Full-time
   b. Part-time
   c. Total employees

E. UTILIZATION: AGE 65 AND OVER

1. Inpatient
   a. Number of admissions for the month
   b. Number of inpatient days for the month

PLEASE CHECK DEFINITIONS

enlarge the scope of the monthly survey. Hospital participation in the survey will continue to be voluntary. In January 1976, 800 hospitals from the 1975 AHA panel of 1000 hospitals and 1200 new hospitals were invited to participate in the joint AHA/ORS survey. As of May 1976, 650 of the 1200 new hospitals solicited and 700 of the original AHA panel hospitals had agreed to participate. ORS is optimistic that a sufficient number of hospitals will participate to make the system viable and provide data from a broad spectrum of hospitals.

Once underway, according to the terms of the contract, ORS will pay the AHA $450,000 for two years to finance one half the cost of the expanded panel. The AHA will recruit the 2000 hospitals and conduct the actual survey. The names of the individual hospitals participating in the survey will not be given to ORS, but ORS will be told the bed size and county code of each participating hospital. Thus, although ORS will not be able to match the monthly survey questionnaires to hospital names, they will know the hospital size and county specific sociodemographic data for each. An independent auditor, acceptable to both parties and selected on the basis of bids to SSA, will audit the data submitted by a sample of the participating hospitals. Again, the names of audited hospitals will not be disclosed to ORS.

The present AHA survey questionnaire will be expanded from 36 to approximately 100 questions. The new questionnaire will retain the present revenue, expenses, current assets, and current liabilities questions, but will also request inpatient and outpatient utilization and salary expense breakdowns by hospital service units. A draft of possible expansion items to the AHA survey questionnaire (shown as Exhibit 8 on the previous page) appears on the following page as Exhibit 9. The proposed survey form will be field tested before the cost monitoring project is fully implemented.

While the new survey instrument is being field tested, ORS will be able to obtain data from the original AHA panel survey from January 1, 1975 from the AHA panel hospitals that have agreed to participate in the cost

EXHIBIT 9: PROPOSED QUESTIONNAIRE FOR HOSPITAL COST MONITORING PROJECT

National Survey of Service Utilization

Report data for a full 12-month period, preferably October 1, 1974 through September 30, 1975.

Indicate period used: Beginning date: __/__/__ (mo.day yr.) Ending date: __/__/__ (mo.day yr.)

SECTION A. UTILIZATION AND REVENUE

1. Routine Services	Utilization Total	Gross Inpatient Revenue	Gross Outpatient Revenue
Acute and Extended Care Inpatient Days		$ .00	.00
Intensive and Cardiac Care Inpatient Days		.00	.00
2. Ancillary Services			
Operating Room Visits		$ .00	$ .00
Laboratory Tests		.00	.00
Nuclear Medicine Procedures		.00	.00
Pharmacy Line Items		.00	.00
Diagnostic Radiology Procedures		.00	.00
Therapeutic Radiology Procedures		.00	.00
Renal Dialysis Treatments		.00	.00
Occupational Therapy Treatments		.00	.00
Physical Therapy Treatments		.00	.00
Pathology Tests		.00	.00
Delivery Room Births		.00	.00
Other Ancillary Services		.00	.00

3. Total Deductions from Patient Revenue $_____.00

EXHIBIT 9 CONTINUED

SECTION B. MAN-HOURS AND EXPENSES

1. Service Area	Man-Hours	Salary Expense	Other Direct Expense
Nursing Services (Medical and Surgical Units)			
Registered Nurses		$ .00	$ .00
Licensed Practical Nurses		.00	.00
Other Nursing		.00	.00
2. Ancillary Services			
Operating Room		$ .00	$ .00
Laboratory		.00	.00
Nuclear Medicine		.00	.00
Pharmacy		.00	.00
Diagnostic Radiology		.00	.00
Therapeutic Radiology		.00	.00
Renal Dialysis		.00	.00
Occupational Therapy		.00	.00
Physical Therapy		.00	.00
Pathology		.00	.00
Delivery Room		.00	.00
3. General Services			
Housekeeping		$ .00	$ .00
Plant Engineering		.00	.00
Administrative and Fiscal		.00	.00

Date of Completion

Signature and Title

If there are questions about responses to this survey, who should be contacted?

Name (Please print)

( ) Area Code Telephone number

EXHIBIT 9 CONCLUDED

Tentative List of Items for the Output Price Index

Description	Unit of Measurement
Medical-Surgical Unit	Daily Charge (semi-private)
Intensive Care Unit	Daily Charge
Coronary Care Unit	Daily Charge
Operating Room	Hourly Fee
Recovery Room	Hourly Fee
Emergency Room	Fee per Visit
Laboratory Services	Charge per CBC
Special Diagnostic Tests	Charge per ECG
Pharmacy	(1) Charge per single dose: Tetracycline 250 m.g. P.O.
	(2) Charge per 1000 cc 5D/W
	(3) Charge per single dose: Nembutal 100 m.g. P.O.
Radiology	Charge per P.A. and Lateral Chest X-ray (adult)
Inhalation Therapy	Charge per day: O_2 Tent
Physical Therapy	Charge per treatment: Hydrotherapy (Hubbard-tank)
Central Supply	Charge per Foley catheter

monitoring project. It is hoped that this provision will furnish historical data on approximately 800 hospitals from the AHA survey.

When the new cost monitoring project is fully operational, the monthly survey questionnaire will be returned by the hospitals to the AHA. Then, after deleting the names of the hospitals, copies of the questionnaire responses will be forwarded to ORS. Under the terms of a second contract between ORS and Applied Management Sciences, Inc., the data will be abstracted and processed for the computer.

ORS hopes that the information from the panel will enable current monitoring and reporting of costs, prices, service intensity, unit input costs, technology, and productivity in short-term general hospitals. They hope to create a data base and information retrieval system that will allow greater availablity and/or increased utilization of services to be related to hospital costs and prices. If this goal is realized, it would then be possible to disaggregate hospital cost and price increases into various components such as increased service intensity or unit input costs. Based on this data, ORS intends to make state by state estimates of the cost and utilization of hospital service.

A major rationale behind the cost monitoring project is the hope that it will provide an historical data base for state rate review activities that may be initiated in the future. The expansion of the AHA panel to 2000 hospitals will allow reliable state estimates of the values of most of the variables contained in the questionnaire and should facilitate the monitoring of hospital costs. However, the project is not to be viewed as a regulatory mechanism. In addition to the prohibition against disclosure of hospital names to ORS, the contract also contains additional safeguards that prohibit ORS from using the data provided by the hospital to set a reimbursement rate for the hospital. Specifically, the contract states:

> Data provided by a specific hospital under the contract shall not be used to insure compliance with existing federal legislation by the individual hospital.

However, ORS maintains that aggregate data from the panel could be used to determine an average cost as part of a rate determination formula and then applied to a group of hospitals. ORS would not view inclusion of panel hospitals in the group as a violation of the terms of the contract.

Section 5: Discussion

The Medicare cost reports currently represent the major public source of national data on hospital cost and operating expenses. Although revisions have been made to conform with new requirements in the Social Security Act or regulations, the Medicare cost reports have continued to require hospitals to submit basically the same types of data for each of the last ten years. The question then becomes: is this wealth of historical data on hospital costs a useful source of information on the reimbursement aspects of the Medicare program and the cost trends and financial status of the hospitals that serve Medicare patients? Unfortunately, the answer is that it is not. For example, in 1971 when the federal Cost of Living Council was designing the Economic Stabilization Program, they were unable to obtain uniform cost data on hospitals from within the federal government and had to go to the hospital industry itself. Many of the reasons for this inadequacy and some of the recent attempts to circumvent the problems have already been discussed. These observations are reviewed and summarized below.

First, the Medicare cost reports are designed to serve the administrative needs of the program which are to arrive at a bottom line figure for the amount of reimbursement owed to each provider each year by the Medicare program for services rendered to Medicare beneficiaries. It is beyond the scope of this report to comment on whether the data on the cost report provides an adequate and accurate determination of the hospital's annual reimbursement from Medicare; we will assume that it does.

As a result, however, although the Secretary of DHEW has the statutory authority to request any information necessary for reimbursement from

the hospitals and to withhold payment if the hospital fails to furnish requested information, this authority has only been exercised to request the information needed for purely administrative purposes, i.e., to implement existing program policies and to follow existing procedures. Data from the cost reports focuses on paying the individual hospital and does not meet the broader needs of assessment of program impact, research on future policy options, or even hospital cost comparisons as required by Section 223 of P.L. 92-603. The cost reports are designed to compute allowable versus non-allowable expenses to derive a bottom line figure for the "reasonable cost" of providing services in that hospital to Medicare beneficiaries. The ORS sample cost report analysis project is attempting to use simulation techniques and regression analyses to provide some guidance for reimbursement policy decisions based on their sample of cost reports, but, recognizing the inadequacies of the cost report data, ORS has had to go outside the SSA system to obtain supplementary cost data through its Hospital Cost Monitoring Project monthly system.

Second, a major problem with cost report data as well as data contained in the certification application is that there are insufficient controls on the quality of data that permit hospitals to report sloppily or fail to complete questions not directly linked to the calculation of their reimbursement. If a hospital feels a data item is unused and therefore irrelevant, there is no incentive to provide an accurate and adequate response. This attitude on the part of the hospitals can be traced to Medicare data policies. The authority of the Secretary of DHEW to withhold reimbursement if the forms are not complete has been used only for items directly linked to reimbursement. Since reimbursement determination is the only area in which Medicare provides the hospitals with feedback showing how the data they submitted are being used, it is not surprising that reimbursement-linked data receive a level of attention and completion not accorded to other data inputs.

Moreover, since the fiscal intermediary is primarily concerned with determining the bottom line figure to ascertain how much the hospital

is owed by or owes to SSA for services to Medicare beneficiaries, intermediary review efforts naturally focus primarily on verifying figures necessary to determine reimbursement. Furthermore, the existing methods of reimbursing intermediaries offer no incentives to them for improving the statistical data. At SSA, no unit interviewed would take responsibility for review of the quality of the data submitted.

Third, although the use of fiscal intermediaries provides local level data collection, it also creates a middle step in the flow of data from hospitals to SSA and impedes SSA's ability to generate current information on hospital costs and utilization under Medicare. Since the cost reports are not forwarded to SSA until final settlement is made by the intermediary, some cost reports were reported to be two or three years old before even reaching SSA.

Fourth, within the Bureau of Data Processing (BDP), Medicare cost report data processing often remains undone or seemingly takes an excessive amount of time for completion. As previously noted, the Cost Analysis Branch of BHI maintains that BDP fails to process the abstracted cost report data since its processing is not an administrative priority. Some ORS staff contend that their responsibility for generating timely Medicare statistics is thwarted by BDP's lack of cooperation in giving ORS programming assistance or computer time. Other ORS staff indicate that they can obtain programming services from BPD only by paying premium overhead for programmers, i.e., $32,000 for a $16,000 per year programmer.

Fifth, as a result of the time delays, processing, and computerization problems previously discussed, the BHI Cost Analysis Branch has been unable to produce current statistically sound cost data, to evaluate the Medicare program's share of total health costs, or to establish standards to identify out-of-line providers. Additionally, because this unit was unable to fulfill its functions, it was never used as a means of screening out unnecessary data items from cost reports. The result is that the Cost Analysis Branch is viewed both within BHI and in ORS as

a repository of settled cost reports awaiting computer processing that will never occur. Because this branch has failed to pull together the Medicare data into a usable form, both ORS and other BHI components go directly to the the intermediaries to obtain needed cost reports and then analyze them manually (as is done by BHI to set the ceilings on reimbursement under Section 223) or contract with outside agencies for computer processing (as is done for the sample cost report project).

Another example of the problems encountered in attempting to use Medicare cost data is a recent ORS attempt to assess the impact of Medicare on hospitals' financial status. In 1972, Karen Davis and Richard W. Foster published a study, "Community Hospitals: Inflation in the Pre-Medicare Period," which sought to identify the causes of hospital inflation in the years immediately preceding Medicare by examining a number of inflation theories with data on components of hospital revenues and expenses for fiscal years 1962 - 1966. This study was based on audited accounting statements for approximately 400 hospitals for these five fiscal years. Obtained through a contract with the American Hospital Association, these statements included balance sheets; profit and loss statements; departmental breakdown of revenue and expenses; utilization data such as beds, admissions, patient days and outpatient visits; and data on hospital personnel and expenses. After Medicare's implementation in 1966, ORS was supposed to redo the study on the same 400 hospitals to determine the impact of Medicare.

It was decided that SSA should use its own Medicare cost reports to obtain the necessary data instead of requesting each hospital to submit their audited accounting statements again. Because the cost reports had not yet arrived at SSA this could not be accomplished. ORS then went directly to the fiscal intermediaries for the data, but found that many of the cost reports were not yet available even from the intermediaries. Thus, ORS was not able to perform a post-Medicare analysis comparable to the pre-Medicare analysis.

Meanwhile, the AHA independently redid the study of the original 400 hospitals by obtaining releases from the hospitals and using their audited accounting reports. It is a sad commentary that SSA is unable, considering the vast amount of data available to it, to generate a report evaluating the financial impact of such an important program as Medicare on the hospital system, and must depend on evaluations produced by the hospital industry itself.

The recent progress of the Office of Research and Statistics in obtaining and analyzing the sample of 1200 cost reports for each of the years 1971, 1972 and 1973 as well as the development of the soon to be operational Hospital Cost Monitoring Project are commendable efforts to supplement the gaps in Medicare hospital cost data.

Equally encouraging are the Bureau of Health Insurance's plans to implement a "Limited Data Abstraction Program" in which the fiscal intermediaries would abstract approximately two pages of information (roughly 80 data items) from the cost reports. The abstracted data would be forwarded to SSA immediately after desk review. By eliminating the time lag between desk review and final settlement for transmission of data and by having the data abstracted at the intermediary level instead of centrally at SSA, timely transmission of cost report data may finally be achieved. It is hoped that the new program will be operational by January 1977.

While these efforts represent a significant advance in the development of a national data base on hospital costs, they leave unresolved the question of how to relate systematically SSA hospital cost information to the rich store of data on hospitals derived from SSA's basic record files, outlined in Parts II and III of this report.

PART V. ADAPTING THE MEDICARE DATA BASE TO RATE SETTING NEEDS: SOME STRENGTHS AND LIMITATIONS

If future reimbursement to hospitals under Medicare and/or national health insurance is to be based on some form of prospectively determined reimbursement, the Social Security Administration will undoubtably have to adapt its existing data base to meet new functions and objectives. Notably, some new or more detailed data will have to be collected, the timeliness of information processing will have to be greatly improved, and information integration capability will have to be refined and further developed. The preceding parts of this report have reviewed the types of data collected by SSA on Medicare beneficiaries, participating hospitals, and their interaction as well as the manner in which that data is gathered, analyzed and used. This part discusses some of the strengths and limitations of the current information structure from the perspective of its ability to adapt to alternative applications such as rate setting.

Section 1: Strengths and Limitations of the Medicare Data Base

The Medicare data base seems to serve the administrative needs of the program well--eligibility records are maintained, providers are paid, claims are processed, etc. An analysis of how completely the administrative functions are fulfilled is not within the scope of this paper. However, it is a legitimate question to ask whether this valuable source of nationally based data, besides meeting existing programmatic responsibilities, could also be made to serve the purposes of rate setting--and if so, what changes would then be in order. The final report of this project addresses some of the issues surrounding the information requirements for a rate setting system for hospitals. As background for the final report, and drawing on the material from the preceding parts, this section summarizes the strengths and limitations of the Medicare data base from the perspective of its scope, management, integration and use.

Scope of the Data Base. As discussed in the preceding parts, to meet existing programmatic responsibilities, SSA collects a wide variety of data on the number, demographic characteristics, and geographic distribution of persons covered by Medicare; on the utilization of, and charges and reimbursement for, inpatient hospital services and other covered services; on the number, type, characteristics, and geographic distribution of the providers participating in the Medicare program; on the annual amount of reimbursement to providers from Medicare; and on the utilization of and expenditures for physician and other medical services under Part B. Thus, the Medicare program contains most of the basic ingredients of a population-based data system:* a defined population base with demographic data on the age, sex, socio-economic status, size, and location of that population; resource data on the providers-of-services to that population; utilization data from the requests for payment/claims forms submitted by the providers; and program expenditure data from the providers' annual cost reports. An additional ingredient of a population-based data system, outcome data, are available in terms of morbidity and mortality rates for a 20 percent sample of Medicare beneficiaries, but should be supplemented by special surveys coupled with the PSRO quality-of-care assessment program. Since all Medicare beneficiaries are uniquely identified by their social security/health insurance benefits claim number and all hospitals are similarly identifiable by their provider number, the data in the various computer files can be linked to relate the providers to the beneficiaries served.

The Medicare program data base offers many advantages as a source of population based data. Some of these advantages were reviewed by Clifton Gaus, of the Office of Research and Statistics, in his March 8, 1976 presentation to the National PSRO Council on the benefits of using Medicare data for PSRO evaluations.** First, the data base has been operational for

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* See Jennifer Robbins, The Uses of Population-Based Data for Rate Setting, working paper R-45-5 in this series.

** Clifton Gaus, Ph.D., "Uses of Medicare Data for the PSRO Program," presentation to the National PSRO Council, March 8, 1976.

ten years and is thus capable of producing the baseline data necessary for effective planning and evaluation. Secondly, because the population base is easily defined, the utilization of services can be related to the population at risk and diagnostic specific incidence and prevalence rates by type of admission may be computed. Thirdly, the unique and permanent identification of the beneficiaries in the central records allows a person-based data file to be established. This person-based data file can then be linked with provider and supplier profiles to produce length of stay analyses, and utilization of service patterns. In addition, since the data are already collected for administrative needs, the data base can be used as a statistical data base at a low marginal cost.

However, as the discussion in Part IV reveals, the data from the Medicare cost reports represents a critical gap in this otherwise relatively comprehensive data base. In sum, the cost report data is not linked to the enrollment, utilization, or certification data as a result of the various organizational and technical problems previously reviewed. Moreover, despite the Secretary of DHEW's broad statutory authority to collect whatever data are necessary to determine provider reimbursement, this mandate has been narrowly construed and cost data collection has been limited to the specific data needed to compute reimbursement under existing Medicare procedures and policies. Additional data on the financial status of hospitals, cost trends, or the impact of Medicare reimbursement policies on hospitals has not been collected, although ORS now hopes to obtain some of this type of data from the Hospital Cost Monitoring Project.

The separation of the cost report data from the rest of the Medicare records, while unfortunate, is not surprising. As we have repeatedly emphasized, the Medicare data base was largely designed for administrative purposes, and reflects the biases and interests of the program administrators. The system is beneficiary oriented; it was designed to provide instant access to the records of the 23 million Medicare beneficiaries in order to determine eligibility, compute remaining days of coverage, or coverage status in terms of current spell of illness. The essential linkages are those

between beneficiary eligibility and utilization records and it is those linkages that are kept current in order to meet daily administrative needs. The provider-oriented data, such as the cost reports, are not viewed with the same sense of immediency, since by the time the cost report is submitted to SSA, the provider has already been paid by the fiscal intermediary and the data will only be used for review and monitoring purposes.

It should be noted also that the provider-of-service file that contains resource data derived from the certification process is designed for administrative purposes and serves only to meet the narrow objectives of determining whether the provider complies with the conditions of participation for Medicare. A wide range of data is obtained from the provider on the certification application, but many SSA staffers feel that much of this data is sloppily reported by the providers because hospitals know that it is not directly related to the level of reimbursement received. However, the certification data is expremely important in that it is the basic source of statistical data on the participating hospitals and their scope of services and staffing pattern.

One great strength of the Medicare program's data base is that the decision was made to code diagnostic and surgical procedure data for 20 percent of the Medicare beneficiaries, giving the program a splendid case mix review capability not available to any other third party payers. It was wise to use only a 20 percent sample instead of coding all claims data because the sample use reduces the processing costs and provides the desired data in a more timely and less cumbersome manner.

The use of household survey techniques in the Current Medicare Survey to gather data on out-of-program utilization that is otherwise unobtainable is an example of one means to address the deficiencies of the existing system. The Hospital Cost Monitoring Project provides another example. The special studies approach to obtaining data is an effective means of generating data necessary to address specific issues without overburdening the system by obtaining this broader scope of information on all 23 million beneficiaries.

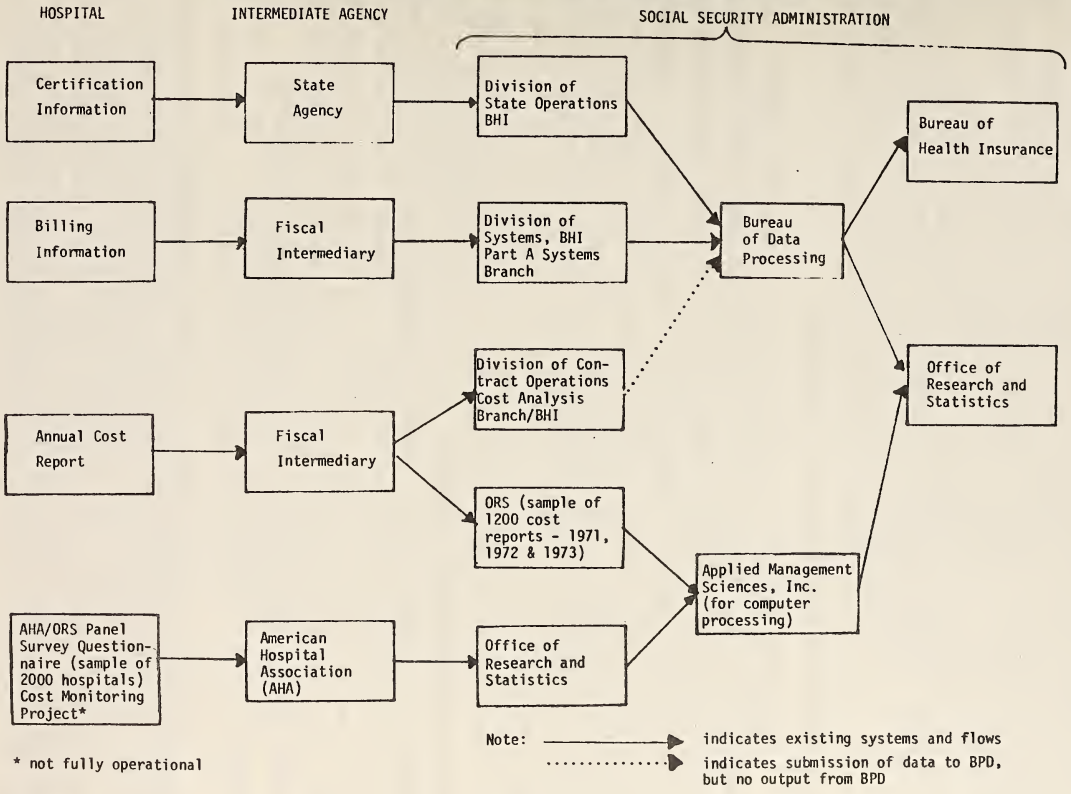
Quality of the Data. The discussion in each of the preceding parts has cited problems with the quality of some of the types of data collected by SSA. The major problem areas concerned the certification data, the cost report data, and the diagnostic and surgical procedure data from the claims form. For both certification and cost report data, the quality problem was attributed to the failure to relate the data requested directly to the reimbursement received by a provider. In other words, the provider often left items blank or reported sloppily if it was felt that the data supplied had no impact on reimbursement. Therefore, the use of such data for reimbursement determination would most likely result in much more attention being given to the quality of the reporting.

The quality problems in the diagnostic and surgical procedures portion of the claims forms are more difficult to remedy. The claims form is completed by the hospital billing department, not the medical records department. As a result, some feel that the diagnostic claims data may frequently be inaccurate due to the quality of information transmitted by the hospital departments as well as to clerical errors or misinterpretations by the billing office staff who are not trained in medical terminology. ORS is currently undertaking a validity study to compare the accuracy of the diagnostic code with the primary diagnosis as it appears on the face sheet of the medical record. The results of this study could be used to identify the areas of weakness and upgrade the overall quality of claims data.

Management of the Data Base

Collecting the Data. Through the Medicare program's administrative structure, SSA has the capability of collecting and organizing data on the local, regional and national level. The use of state agencies in the certification process, and fiscal intermediaries in the payment and auditing process, allows Medicare data to be collected and aggregated at the local level. The chart on the following page depicts the flow of Medicare data. This local level

CHART 2: FLOW OF MEDICARE INFORMATION FROM THE INDIVIDUAL HOSPITAL TO SSA



* not fully operational

collection system has the advantage that the data collector operates in close proximity to the data supplier. The supplier can thus be easily consulted to check the accuracy of submitted data or be assisted in completing the forms. In fact, the fiscal intermediary is paid both to process the claims and cost reports and to provide technical assistance to the hospitals. Another advantage to having the fiscal intermediary at the local level is that this position allows the intermediary to be aware of local circumstances and conditions that may require adjustments to national norms or explain variations from national trends.

The DHEW structure of regional offices in Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco and Seattle provides a link between the central SSA offices in Baltimore and the state agencies and fiscal intermediaries at the local level. Interpretation of policy and procedures as well as reviews of state agency and intermediary activities is provided on a regional basis. If desired, local data can be aggregated for each of DHEW's 10 regions to permit analysis of regional trends.

All data collected at the local level by intermediaries or state agencies is eventually transmitted to the SSA central headquarters in Baltimore. SSA's Bureau of Data Processing operates one of the largest and most advanced computer systems in the federal government, if not the world. Thus, all Medicare data is centrally computerized and stored in one national center. Data can be retrieved by users on a national basis or broken out by variables such as age group (for 65 and over) of beneficiary, sex of beneficiary, type of hospital, or by county and/or state.

Processing the Data. The description in Part IV of the processing of the cost reports clearly reveals the significant limitations to processing cost data in a timely fashion. The long delays in receiving the cost reports, the abstracting time in the Cost Analysis Branch of BHI, and the failure to obtain the cost report print-outs from the Bureau of Data Processing (BDP) impair SSA's ability to produce usable cost data on hospitals in a timely

fashion. These processing deficiencies have resulted in ORS's outside contracts with a private firm to abstract and process their sample cost reports and the data from the Hospital Cost Monitoring Project. Also, BHI is planning a "Limited Data Abstraction Program" in which the intermediaries abstract and forward the cost data before final settlement has been made. It is obvious that substantial changes in the processing priorities and capabilities would have to be made if SSA were to move to a rate setting program of its own or a monitoring function for state rate setting activities.

On the other hand, the eligibility and claims data are processed promptly because the program's administrative requirements necessitate continual updating and currency for these files. There are also far fewer problems in handling certification data than in processing cost data at SSA. This is perhaps partially due to the lesser volume of data in the certification form--the certification application is a four page form, while the cost report is approximately forty pages. Also, certification data is transmitted directly from the state agency to SSA in Baltimore from computer terminals located in the regional offices. Unlike delays due to disputes over actual level of reimbursement on the cost reports, the certification application is not subject to lengthy debates between providers and the state agency which delay final submission to Baltimore. As a result, the certification data can be processed and integrated with the Medicare claims data as part of Medicare's data base.

Data Integration and Use

Since Medicare is a federal program, all states are required to participate and all participating providers must use the definitions, procedures, and principles set by the federal government. The same claim forms are used for Medicare beneficiaries whether they are hospitalized in rural Kansas or New York City; in a proprietary, voluntary, or government facility; or in a 35 bed or 500 bed hospital. The certification application and annual cost reports request the same data items from all providers. However, at the present time, hospitals are not required to use a uniform accounting system, although the new planning law (P.L. 93-641) does mandate

SSA to develop such a system. While the Medicare system uses common forms, other non-SSA data on hospitals, such as the AHA annual survey data, often use definitions that differ from those of Medicare, making it difficult if not impossible to compare SSA data with that from other sources, or to integrate information from external sources with Medicare data.*

An additional weakness is that the geographic service areas of the fiscal intermediaries do not coincide with the service areas of the PSROs (Professional Standards and Review Organizations) mandated under P.L. 92-603 or the new HSAs (Health Systems Agencies) mandated under P.L. 93-641. Overlapping responsibilities and the failure to designate consistent jurisdictional borders for the three programs promote problems such as duplication of data, lack of coordination and communication, inconsistent disclosure policies and lack of public accountability. This fragmentation of data responsibility promotes, or at least allows, for the use of differing definitions, data formats, and time frames making data integration difficult, if not impossible.

DHEW notes that fragmentation of sources of data and data systems exists at all of its levels. Recognizing the complexity and widespread distribution of responsibility within DHEW for the health statistics systems, an interagency Health Data Policy Committee was established in April 1974 as an advisory body to the Assistant Secretary of Health. In November 1975 this committee published its Health Statistics Plan for fiscal years 1976-1977. Since Medicare data constitutes a major component of DHEW's health data, the findings of this committee should be noted. The Health Statistics Plan concludes that:

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* It should be noted that the definitions used by Medicare are often a result of congressional action and not administrative policy. Thus, SSA often does not have the authority to change the Medicare definitions to conform to those used by national organizations, even were the program willing to do so.

> Health statistics production in this country presents a picture of uncoordinated data collection, aggregation, presentation, and analysis among various Federal, State, local and non-governmental sources. The separate efforts underway are frequently duplicative of one another, and despite common goals, possess little of the continuity, compatibility, and standardization which are essential to a reliable health statistics system. . .Agencies operating on the various health programs tend to make demands on communities for collecting or providing data specific to their own mandated program needs for planning, monitoring, and evaluating, with little effort towards coordination or standarization across program needs. This has resulted in overlapping, redundant data collection activities with unnecessary burdens on respondants and produces volumes of expensive data that cannot be aggregated because of a lack of any compatability or standarization which are essential to a coordinated health system.*

While these comments were written in regard to the overall DHEW health statistics system, SSA's internal statistics system suffers from similar problems. The failure to integrate cost report data with billing and certification data is a prime example of this.

The recent plans of SSA's Office of Research and Statistics to work with the National PSRO Council to provide PSROs with information on hospital utilization patterns from the MEDPAR report series and with the Bureau of Health Planning and Resources Development to explore ways in which the Medicare utilization data can be useful to the health planning program established by P.L. 93-641 are positive signs of improved coordination of data integration between various DHEW components. If these working links can be forged, the geographic patterns of health care utilization by the Medicare population could be used as a first step towards developing means to monitor itilization and plan resources for total populations.

Exhibit 10, on the following pages, briefly summarizes some of the strengths and limitations for prospective rate setting purposes, of the Medicare data base.

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* U.S. Department of Health, Education, and Welfare, Health Statistics Data, Fiscal Year 1976-1977, November 1975, p. 20.

EXHIBIT 10: SUMMARY - THE MEDICARE DATA BASE FOR RATE SETTING PURPOSES

Strengths	Limitations
Scope of the Data Base	
- Data base contains major ingredients of population-based data system: demographic data, resource data, utilization data, program expenditure data, and outcome data.	- The annual cost report data are not linked to the patient-related data or to the resource data. - There are huge gaps in analyzed data on health care costs, financing and prices.
- The population receiving services can be linked to the utilization of services - utilization from the perspective of people served rather than institutions.	- Data is for utilization of Medicare beneficiaries only - projections based on the elderly and disabled are not reliable indicators for the whole population.
- All beneficiaries and providers are uniquely identified, allowing person-based data files to be developed. - Household surveys and special studies are used to obtain supplemental data.	- The present system is not designed to measure changes in accessibility to services, the way services are provided, the nature of facility used, and other factors involved in the changing financing and delivery patterns at the state and local level.
- Diagnostic and surgical procedure data are available for a 20% sample of beneficiaries.	- Diagnostic and surgical procedure data are the weakest data elements in the statistical system due to quality problems.
- The data base is 10 years old and could be used for historical trend analysis and to produce base line data.	
Management of the Data Base	
- The use of state agencies for certification and fiscal intermediaries in payment and auditing process allows data to be collected and aggregated at the local level; data collectors operate in close proximity to data suppliers--unique local conditions can be identified to help explain variations from national norms.	- The transfer of data from local level to SSA central headquarters creates delays; most of the data presently collected is not current by the time it is made available for review and analysis.

Strengths	Limitations
	- SSA central units must go directly to intermediaries to obtain current cost reports.
- In cooperation with NCHS, SSA is now capable of producing data by PSRO, HSA, or fiscal intermediary service area.	- SSA's fiscal intermediary service areas do not coincide with PSRO and HSA data collection areas. - Lengthy delays and poor coordination between BHI and ORS in processing the data exist, especially with cost report data.
Integration and Use of the Data Base	
- Medicare is a uniform national program, so the providers in all 50 states use common forms, definitions, etc.	- Medicare definitions and reporting instruments frequently do not conform to those used by other groups, such as the AHA or other HEW components. - Many definitions used in the cost reports are subject to varying interpretations leading to inconsistent reporting.
- The DHEW Health Data Policy Committee provides a mechanism for the development of common policies for data collection and use to avoid duplication and promote effective data sharing.	- The fragmentation of data responsibility among PSROs, HRAs, and SSA for Medicare promotes duplication of data and frustrates the ability to integrate effectively data from multiple sources.

Section 2: Forecasting Future Needs for a Data Base for Rate Setting

If rate setting were mandated for the Medicare program, significant alterations would have to be made in the existing data base and its management. The precise changes cannot be specified until the goals and objectives of the rate setting approach to be used are themselves specified. However, a few summary observations can be made regarding the nature of some of the changes in Medicare information capability that would be necessary.

Information on utilization, case mix and patient characteristics and

on staff, program and facility resources are all essential adjuncts to cost information in establishing prospective rates for hospitals. SSA currently collects some of the information required, but would have to develop increased collection and integration capabilities to accomodate to the needs of rate setting. Most notably, the cost report package would have to be revised from an administrative tool for retroactively calculating reimbursement in accordance with narrowly defined principles to a future-oriented budget analysis and rate review package. Moreover, unlike the existing system, this cost data must be integrated with the utilization, statistical and planning data derived from Medicare itself or from outside sources. Ideally, Medicare rates would then be set by relating cost information to the nature, quality, volume, efficiency and effectiveness of the services rendered by the hospitals and to the needs of patients who receive those services. Ultimately, one must also assess these services in regard to their effect on the health and well-being of the community and patients served. The existing system needs massive restructuring and reform before it can begin to meet these global needs, but it has a strong and well developed data base on which to build.

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APPENDIX A: THE ADMINISTRATIVE STRUCTURE OF MEDICARE

[The information on which this appendix is based was current as of January 1976.]

APPENDIX A: THE ADMINISTRATIVE STRUCTURE OF MEDICARE

Administrative responsibility for the Medicare program is assigned by the statute to the Secretary of the Department of Health, Education, and Welfare (DHEW). Section 1874 of the Social Security Act (42 U.S.C. § 1395 kk) states:

> Sec. 1874. (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1937, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.
>
> (b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

Thus, at the federal level, the Secretary of DHEW and the various components of DHEW under his direction are responsible for the administration of Medicare. However, the statutory provision allowing the Secretary to contract out for performance of his functions grants the Secretary the authority to obtain the services of agencies of state government and of Blue Cross plans and insurance companies as fiscal agents.

As a result of legislative negotiations surrounding the enactment of Medicare, the fiscal agents for Part A, known as fiscal intermediaries, were interposed between the Department of Health, Education, and Welfare and the various providers of service and assigned, on a contract basis, many of the daily administrative responsibilities of Medicare. Under the authority of Section 1816 of the Social Security Act (42 U.S.C. § 1395 h), the Secretary of DHEW contracts with the fiscal intermediaries to facilitate payment of providers of service, to provide consultative services to providers, to act as the liaison between DHEW and the providers, and to audit providers.

Since the information generated by the Medicare program is a by-product of the administrative process, a brief description of the

administrative structure is provided in this appendix to facilitate the reader's understanding of the flow of information within the Medicare program. Section 1 on the role of the Department of Health, Education, and Welfare identifies the components of DHEW with responsibility for the Medicare program and briefly describes the role of each component. Section 2 reviews the functions of the Division of Provider Reimbursement and Accounting Policy of the Social Security Administration's Bureau of Health Insurance. In Section 3, the role of the state agencies and fiscal intermediaries under contract to provide services for Medicare are discussed.

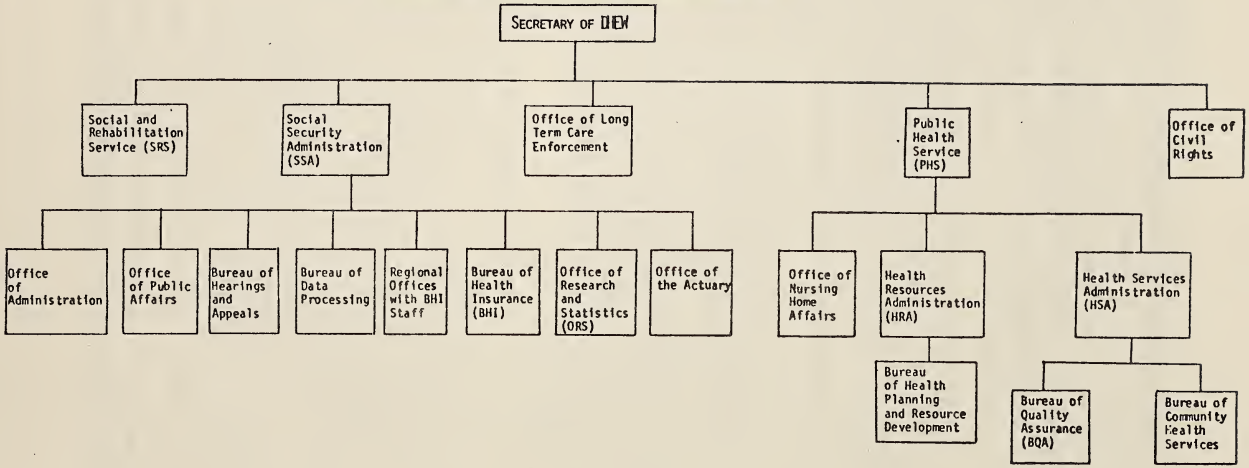
Section 1: The Role of the Department of Health, Education, and Welfare

Although responsibility for the administration of Parts A and B of the Medicare Program is vested by law in the Secretary of the Department of Health, Education and Welfare (DHEW), within DHEW, responsibility for policy formulation and the general management and operational aspects of the program are assigned to the Social Security Administration (SSA). Within SSA primary responsiblity for the operation of the Medicare program rests with the Bureau of Health Insurance (BHI).

However, in addition to BHI's Medicare responsibilities, other DHEW components are assigned special responsibilities in the administration of Medicare. The Assistant Secretary for Health of DHEW has the responsibility for providing overall guidance in matters of health policy. Under the Assistant Secretary's direction, special responsibilities in connection with the health care standards of Medicare have been assigned to the Public Health Service. The regional Offices of Long Term Care Standards Enforcement direct enforcement of Federal standards for long-term care facilities. Certain responsibilities regarding the relationships between Medicare and state Medicaid programs are coordinated by the Social Security Administration and the Social and Rehabilitation Service of DHEW. Responsibility for assuring compliance by participating providers with Title VI of the Civil Rights Act of 1964 is given to the Office for Civil Rights of

CHART 3

COMPONENTS OF DEPARTMENT OF HEALTH, EDUCATION AND WELFARE RESPONSIBLE FOR MEDICARE ADMINISTRATION AND COORDINATION



DHEW. When Medicare was enacted, the Health Insurance Benefits Advisory Council (HIBAC) was created to provide direction for the Secretary of DHEW on matters of general policy with respect to the Medicare program. However, HIBAC's role was substantially reduced to that of offering suggestions and general advice in 1972 with the passage of P.L. 92-603, the 1972 Amendments to the Social Security Act.

The structure outlined above reflects the federal level responsibilities for the administration of Medicare. At the local level, SSA negotiates and administers agreements with the intermediaries and carriers that perform payment and other program functions and with the state agencies that certify health facilities for participation in the program.

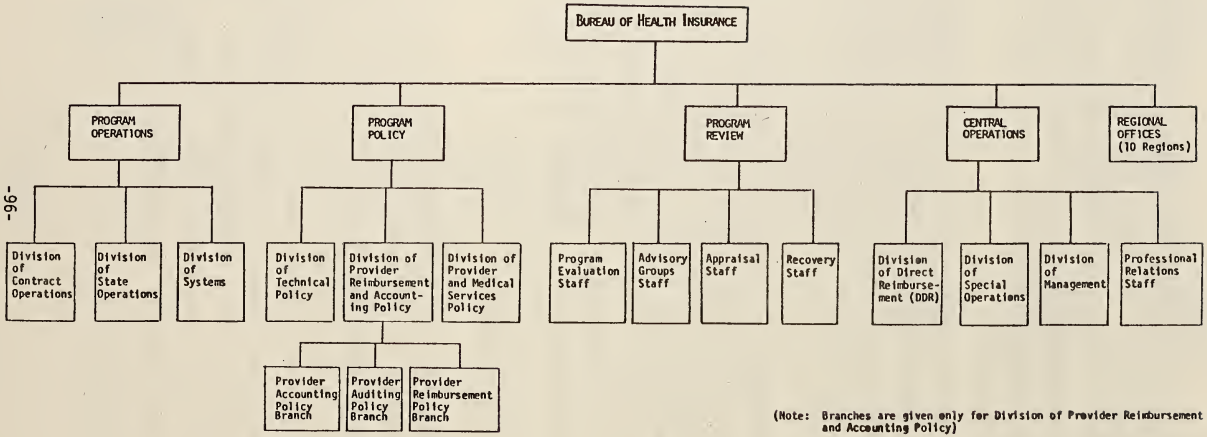
The organizational structure and programmatic responsibilities for Medicare of each of the parties identified above are described in this section. The structure and function of BHI's Division of Provider Reimbursement and Accounting Policy is described separately in Section 2. It should also be noted that this description focuses on those responsibilities related to Part A (hospital insurance) and the relationship between the Medicare program and hospitals as providers of care.

Social Security Administration

The Bureau of Health Insurance (BHI) is the component of SSA primarily responsible for the overall administration of the health insurance program. Other SSA components include the Office of Administration, the Office of Research and Statistics, the Office of the Actuary, the Office of Public Affairs, and the Bureau of Data Processing. The role of each of these components is described below. In addition to these components, SSA also has a field organization that includes approximately 1,300 district and branch offices and more than 3,000 contact stations throughout the country. These field offices carry out the beneficiary enrollment activities and assist the intermediaries and carriers in certain claims development and investigative activities.

CHART 4:

ORGANIZATIONAL COMPONENTS OF BUREAU OF HEALTH INSURANCE



(Note: Branches are given only for Division of Provider Reimbursement and Accounting Policy)

Bureau of Health Insurance. The central staff of the Bureau of Health Insurance is divided into four major components: Program Operations, Program Policy, Program Review and Central Operations. Program Operations is responsible for the negotiation and administration of agreements with the intermediaries and carriers that perform payment and audit functions (Division of Contract Operations); with the hospitals and other providers of service for which the program makes reimbursements (Division of State Operations) and with the state agencies that review and certify health facilities for participation in the program (Division of State Operations). The Division of State Operations also works with the Public Health Service in the formulation and periodic review of the conditions of participation. In addition, the computer record-keeping and data processing functions required for administration of the program come under the purview of the Division of Systems of the Program Operations component.

The Program Policy component consists of four sections: the Recovery Staff, the Program Evaluation Staff, the Appraisal Staff, and the Advisory Groups Staff. The Program Evaluation Staff is responsible for identifying instances of provider fraud and/or abuse and working with the Regional Office staff to investigate suspected fraud and abuse. The Recovery Staff then seeks to obtain repayment on those monies improperly paid to providers. As their unit names imply, the Appraisal Staff and Advisory Groups Staff provide support staff services for the Health Insurance Benefits Advisory Council (HIBAC) and the study groups that review and evaluate the Medicare program.

The Central Operations component is responsible for the general management of the Bureau of Health Insurance including professional relations, training and career development, fiscal services, and health insurance inquiries. In addition, the Division of Direct Reimbursement (DDR) is located in the Central Operations component. If a provider chooses not to deal with one of the fiscal intermediaries available in its geographic area, the provider can deal directly with the government and is serviced by the

Division of Direct Reimbursement. For those providers, as well as all federal and most state and municipal hospitals, DDR performs the same bill processing, payment, and auditing function as the other fiscal intermediaries.

BHI Regional Offices. In addition to the central BHI staff in Baltimore, BHI has representatives in each of DHEW's 10 regional offices: Boston, New York, Philadelphia, Atlanta, Chicago, Kansas City, Dallas, Denver, San Francisco and Seattle. The average size of the regional office BHI staff varies from 45 to 65 individuals representing the Contractor Operations Branch, Program Evaluations Branch, State Operations Branch, and District Office and Professional Groups Branch of BHI. The regional office staff reviews the performance of the state certifying agencies, the fiscal intermediaries, and other SSA contractors in their region and submits an annual report on each contractor to the central SSA offices. In addition to this monitoring function, the Regional Office servies as a liaison and information center between BHI central offices and the fiscal intermediaries, carriers, providers, and state agencies.

Bureau of Data Processing. The Bureau of Data Processing (BDP) maintains the millions of records on beneficiary eligibility, utilization of covered service, and deductible status under Medicare. BDP sends premium notices to and maintains the medical insurance premium (Part B) payment notices for the approximately 3.25 million enrollees who make direct payments or whose premiums are paid through a private retirement group policy or state "buy-in" agreement. In addition to the Medicare records, BDP is also responsible for the electronic data processing of the records for SSA's other programs such as the Railroad Retirement Benefits Program, Old-Age and Survivors Insurance Program, and Supplemental Security Income Program.

Office of the Actuary. The Actuary's Office has responsiblity for the actuarial evaluation of the hospital insurance and medical insurance programs. The actuarial estimates used to set the medical insurance premium, hospital

insurance deductible and co-insurance amounts, and the hospital insurance premium for uninsured individuals are determined by this office.

Office of Public Affairs. The Office of Public Affairs has primary responsibility for developing and coordinating SSA's information responsibilities. In the area of Medicare, the Office of Public Affairs works with the Bureau of Health Insurance in the preparation of pamphlets, films, visual aids, and other descriptive material for the general public, Medicare beneficiaries, and various professional groups. These materials include explanations and descriptions of program benefits and requirements and claims procedures.

Office of Research and Statistics. The Office of Research and Statistics (ORS) is SSA's chief research resource and has responsibility for all program statistics and for analyses required by the Administration and Congress. ORS maintains a statistical system for the compilation of data derived from SSA program operations and conducts economic and social surveys to obtain information on the characteristics and circumstances of beneficiaries or designated population groups such as the newly unemployed or the disabled.

Within ORS, the Division of Health Insurance Studies has the responsibility for the review and evaluation of the Medicare program. Studies and analyses are made of the extent to which the program meets the medical care needs of the aged and disabled beneficiaries, the impact of Medicare on medical prices and the health care industry, and alternative methods of reimbursement for health care services such as prospective reimbursement for providers. In addition, statistical reports based on Medicare program data from the claims review and payment process are produced and distributed by ORS.

Office of Administration. The insurance compliance staff of the Office of Administration has the responsibility of insuring that Medicare intermediaries and carriers fully comply with the federal equal employment opportunity requirements. Descriptive materials on the multiple units of the Social

Security Administration are often coordinated and produced by the Office of Administration.

Bureau of Hearings and Appeals. The Bureau of Hearings and Appeals directs and administers the hearings and appeals process for SSA beneficiaries and providers. However, as a result of the 1972 Amendments to the Social Security Act, providers under Medicare who have received an unfavorable reimbursement decision by an intermediary for an amount in excess of $10,000 can appeal that decision to a DHEW Provider Reimbursement Review Board.

Public Health Service

Under the direction of the Assistant Secretary for Health of DHEW, the Public Health Service encompasses the Food and Drug Administration; Center for Disease Control; Health Resources Administration; Health Services Administration; National Institutes of Health; Alcohol, Drug Abuse, and Mental Health Administration; and the President's Council on Physical Fitness and Sports. Within the Public Health Service, the Office of Nursing Home Affairs in the Assistant Secretary's Office, the Health Services Administration, and the Health Resources Administration are involved in the administration of the Medicare program. The role of each component is discussed below.

Office of Nursing Home Affairs. The Office of Nursing Home Affairs in the Assistant Secretary's Office monitors and coordinates long-term care activities under Medicare and reviews plans and objectives for conformance with DHEW's long-term care requirements. Through grants and contracts, it attempts to stimulate needed long-term care activities and reforms. This office deals directly with the Office of Long-Term Care Standards Enforcement in the DHEW regional offices, the Office of the Secretary of DHEW, and headquarters elements of SSA, the Social and Rehabilitation Service, and Office of Human Development.

Health Services Administration. The Health Services Administration (HSA) works with SSA in formulating and revising the conditions of participation for providers of services under Medicare, developing policies on the role of state agencies, providing assistance to state agencies in carrying out their Medicare responsibilities, supporting and evaluating experimental approaches to utilization review, and providing professional advice in many technical and medical areas of program administration.

Through its Bureau of Quality Assurance (BQA), the Health Services Administration directs the efforts to assure that the health care services provided under Medicare, Medicaid, and other federal programs are medically necessary and furnished in the most economical manner consistent with recognized professional standards of care. BQA is to work with SSA for the Medicare program and the Social and Rehabilitation Service (SRS) for the Medicaid program to: (1) develop quality assurance standards and policies; coordinate their implementation in federal programs; and evaluate their impact on the utilization, quality and cost of health care services; (2) develop conditions and standards of participation for providers and suppliers of health services under Medicaid and Medicare including health and safety standards and coordinate the applications, monitoring, and appraisal of these providers; (3) develop, interpret, and implement PSRO and related peer review and utilization review programs under Medicare and Medicaid; (4) set policy for the End-Stage Renal Disease provision of the Social Security Act and coordinate with the Bureau of Health Insurance on implementation and monitoring of these policies and determination of information requirements to evaluate the program; (5) develop and implement principles of reimbursement for PSROs and peer and utilization review.

The Bureau of Community Health Services of the Health Services Administration is responsible for developing criteria and policies for enrollment of Medicare beneficiaries in Health Maintenance Organizations. This responsibility is carried out by the Bureau's Program Office for Health Maintenance Organizations.

Health Resources Administration. The Health Resources Administration (HRA) through its Bureau of Health Planning and Resource Development (BHPRD) has responsibility for the implementation of the National Health Planning and Resource Development Act of 1974 (P.L. 93-641, 42 U.S.C. § 300 (k) et seq.). This law calls for the establishment of local Health Systems Agencies (HSAs) and State Health Planning and Development Agencies.

Each HSA will be responsible for areawide health planning and development in its designated region. Some of the specific responsibilities of an HSA are to: prepare a health systems plan and annual implementation plan; provide technical and financial assistance for the development of health resources that implement the plan; review proposed federal health project grants; and assist states in review of health services and facilities needs, including reviews of the appropriateness of existing facilities. In addition, the HSA is to coordinate its activities with planning and regulatory entitites for purposes of improving the health of the area's residents; increasing accessibility, acceptability, continuity, and quality of health services in the area; restraining increases in costs of providing health services; and preventing unnecessary duplications of health resources.

The State Agency will serve as the designated state agency under Section 1122 of Title XI of the Social Security Act. Section 1122 provides for the designation of state and local planning agencies to review recommendations and data in respect to capital expenditures of health facilities under Medicare. If the proposal is turned down by the local planning agency, Medicare will not pay for depreciation or interest on that capital expenditure in the Medicare reimbursement calculation (see Appendix B for further detail).

Office of Long Term Care Standards Enforcement

A regional office of Long-Term Care Standards Enforcement has been established in each of the regional offices. In their regions these offices

are responsible for certification of Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs). The standards for these facilities and coordination between DHEW and the states in monitoring these facilities comes within the responsibility of each Regional Office's Office of Long-Term Care Standards Enforcement.

Social and Rehabilitation Service

The Social and Rehabilitation Service (SRS) collaborates with SSA and the relevant components of the Public Health Service (see preceding paragraphs) on those aspects of program planning, coordination and evaluation involving the interrelationships of the Medicare program with state public assistance and Medicaid programs. SRS is also responsible for providing consultation and general and technical assistance to State Agencies administering Medicaid and other medical assistance programs to assure effective coordination between Medicare and the programs at the state level.

Office of Civil Rights

Before any hospital, skilled nursing facility, or home health agency may become a provider under Medicare, this office must assure that it is in compliance with the provisions of Title VI of the Civil Rights Act of 1964. Title VI of the Civil Rights Act of 1964 prohibits an institution from receiving federal funds if it engages in discriminatory practices on the basis of race, color or national origin. This office also investigates complaints of discrimination.

Section 2: Division of Provider Reimbursement and Accounting Policy

The Division of Provider Reimbursement and Accounting Policy (DPRAP) is a subdivision of the Program policy component of the Bureau of Health Insurance (see Section 1). This division is responsible for formulating and evaluating the reimbursement and accounting policies, procedures, principles and regulations for reimbursement of providers* of Medicare services. The functions of this division have previously been divided between four branches: the Provider Reimbursement Policy Branch, the Provider Accounting Branch, the Auditing Policy Branch, and the Provider Cost Analysis Branch. As will be discussed later, the Provider Cost Analysis Branch has recently (July 1975) been transferred from this division to the Division of Contractor Operations in the Program Operations component of BHI.

Provider Reimbursement Policy Branch

The Provider Reimbursement Policy Branch formulates the basic principles and policies to be followed in reimbursing providers of services and other organizations reimbursed on a cost related basis under Medicare Part A and evaluates the adequacy of these basic reimbursement policies in carrying out the objectives of the Medicare program. When necessary, changes in the principles are promulgated. The Policy Branch focuses on general reimbursement issues and formulates broad policies on reimbursement that are implemented using the procedures and principles developed by the Provider Accounting Policy Branch.

The Policy Branch is responsible for evaluating proposed legislation regarding reimbursement to providers of services, recommending alternative proposals, and evaluating Medicare intermediary reimbursement

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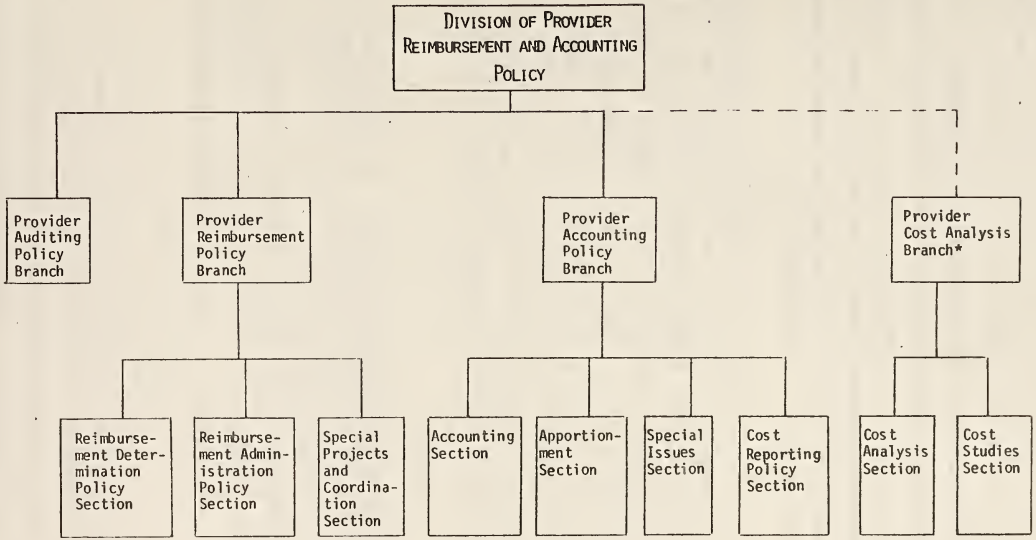
* It should be noted that the term "providers" does not include the physicians who are reimbursed under Part B.

CHART 5:
DIVISION OF PROVIDER REIMBURSEMENT AND ACCOUNTING POLICY (DPRAP)
OF THE BUREAU OF HEALTH INSURANCE (SSA)

(Organizational Structure as of July 1975*)



* In July 1975, the Provider Cost Analysis Branch was transferred from DPRAP to BHI's Division of Contract Operations

practices. Counsel is also provided to intermediaries, providers, and others seeking advice on the application of reimbursement policies and procedures. Some of the Branch's functions include formulation of policies for determining and applying limitations or ceilings on Medicare payments for provider services, appraisal of the effectiveness of the accelerated payments and current financing concepts, and formulation of guidelines for reimbursing providers in atypical circumstances requiring special methods of cost finding and apportionment and reimbursing organizations, such as community health centers, that are not paid on a cost-related basis.

The Provider Reimbursement Policy Branch is divided into three sections: The Reimbursement Determination Policy Section, the Reimbursement Administration Section, and the Special Projects and Coordination Section. While all three sections are responsible for developing the broad reimbursement policies of Medicare, each of the sections is given specific responsibility over a particular aspect of reimbursement policy. However, the specific responsibilities as indicated below are only a partial list of the work of each section, and should only be viewed as an indication of the division of responsibilities within the branch and the scope of issues addressed.

The Reimbursement Determination Policy Section. The Reimbursement Determination Policy Section has been given responsibility for designing the reimbursement policy to implement Section 251 (42 U.S.C. § 1395 x) of the 1972 Amendments to the Social Security Act (Physical Therapy Services and other Services under Medicare) and to provide payment for PSROs under Section 249F (42 U.S.C. § 1301; Professional Standards Review Organizations) of the 1972 Amendments.

The Reimbursement Administration Policy Section. The Reimbursement Administration Policy Section is responsible for developing the regulations for the Periodic Interim Payment Program (PIP) and for formulation of the reimbursement policies to implement Section 221 (42 U.S.C. § 1301) of the

1972 Amendments that places a limitation on federal payments for disapproved capital expenditures.

Special Projects and Coordination Section. The Special Projects and Coordination Section is responsible for determining and applying the limitations on program payments for provider services mandated by Section 223 of P.L. 92-603 (42 U.S.C. § 1395 x) and for formulating and evaluating policies where special reimbursement controls are indicated.

Provider Accounting Policy Branch

The Provider Accounting Policy Branch formulates accounting policies and cost reporting and reimbursement determination procedures for the implementation of provider reimbursement policies and devises cost reporting and reimbursement determination forms and related instructions that accommodate the numerous existing provider record-keeping systems. Analyses are made of cases of misapplication of reimbursement policy revealed by audit, cost analysis, program integrity or other activities and appropriate corrective action recommended. Providers' accounting, data collection and record-keeping practices are reviewed and changes recommended when necessary to meet program requirements. This branch participates in evaluating intermediary Medicare reimbursement practices and counsels intermediaries, providers, and others seeking advice on the application of reimbursement policies and procedures. Liaison is maintained with organizations and individuals involved in the accounting and auditing aspects of health care organization.

Some of the specific tasks undertaken by the Provider Accounting Policy Branch include clarifying the program position on asset values for proprietary providers determined by appraisals, issuing supplementary cost reporting forms dealing with computation of the return on equity capital for proprietary hospitals, clarifying program accounting policy for computing gain or loss on disposition of assets, and issuing supplementary cost

reporting forms for computing the optional allowance for depreciation. Another area of branch responsibility has been the development of policies and accounting procedures for the operations of hospital chains and the adaptation of cost apportionment procedures to accomodate providers that are part of chain operations as compared with individually operated providers

The branch is divided into four sections: the Accounting Section, the Apportionment Section, the Special Issues and Coordination Section, and the Cost Reporting Policy Section. The Accounting Section of the branch formulates and evaluates Medicare accounting policies and procedures for the determination of allowable costs of providers of Medicare services and develops alternative accounting policies that are needed for various types of providers. The Apportionment Section is responsible for the formulation and evaluation of Medicare accounting policies and procedures for the cost finding and apportionment of allowable costs of providers for Medicare services. If necessary, this section devises alternative accounting approaches for cost finding and apportionment to suit the needs of various providers. Consultation is provided to providers and intermediaries on questions regarding cost finding and apportionment procedures. The Special Issues and Coordination Section is responsible for the development of accounting policies and procedures for reimbursing providers in atypical circumstances requiring alternative methods of cost finding and apportionment and for reimbursing organizations paid on a cost related basis such as group practice prepayment plans and community health centers.

The Cost Reporting Policy Section of the Accounting Policy Branch is responsible for the development of all reporting forms, schedules, and instructions necessary to carry out program requirements for reimbursing providers and other organizations reimbursed on a cost related basis. The section conducts an ongoing appraisal of the utility of such forms, schedules, and instructions in implementing reimbursement and accounting policies and procedures and revises the forms as appropriate. Many of the forms revisions are accomplished by issuing intermediary letters

that provide instructions on how existing forms are to be modified rather than redesigning and issuing new forms each time the Medicare statute or regulations are altered.

Provider Audit Policy Branch

The Provider Audit Policy Branch is responsible for the development of a uniform desk review audit program for use by fiscal intermediaries when auditing Medicare providers. The program calls for review of completed cost settlements in terms of the resources employed and costs incurred, the effectiveness achieved and the responsiveness of the program to Bureau requirements. Evaluations are made of intermediary implementation of audit policy and intermediaries are counseled in the application of the total provider cost report review and program audit policy.

The development of a uniform desk review for intermediary audits is viewed as a method of enforcing reimbursement policy by further ensuring the validity of cost reports and by allowing discrepancies in provider costs to be identified before final settlement is made. The uniform desk review procedures include tests indicating aberrant costs that should be investigated before settlement to be used by intermediaries when reviewing the cost reports of providers. By implementing the uniform desk review SSA hopes to standardize the procedures used by intermediaries.

Provider Cost Analysis Branch

As a Division of Provider Reimbursement and Accounting Policy component, the Provider Cost Analysis Branch was to develop an ongoing statistical analysis of reported provider cost, utilization and statistical data. This analysis was to be used by the Branch and other components of BHI to monitor the application of reimbursement and accounting policies and procedures and to evaluate the adequacy of such policies and procedures. The Cost Analysis Section was to receive and store all provider cost reports

from intermediaries, and then to abstract selected statistics from the cost report for coding into the computer. The Special Studies Section was to conduct special analyses and studies of the cost reports in regard to specific issues for the purpose of identifying provider practices or program requirements that warrant evaluation and possible change.

As discussed in Part IV on cost reports, the Provider Cost Analysis Branch has been unable to fulfill many of its functions. In July 1975 it was transferred from DPRAP to the Division of Contractor Operations.

Section 3: Contract Agencies

Some of the specific responsibilities for the administration of Part A of Medicare are contracted out by the Secretary of DHEW to agencies of state government and private organizations. There are two types of private organizations--fiscal intermediaries and Professional Standards and Review Organizations (PRSOs). These intermediate agencies serve as the link between DHEW at the federal level and the individual hospitals at the local level.

In the daily functioning of Medicare, hospitals deal directly with the fiscal intermediary on issues pertaining to reasonable cost determination and reimbursement of those costs under Part A of Medicare. The state agency, usually the Department of Health, is responsible for determining whether prospective providers of service under Medicare Part A meet the conditions of participation. The PSROs, created pursuant to the 1972 Amendments to the Social Security Act, are responsible for reviewing the utilization of services under Medicare as well as under the Medicaid and Maternal and Child Health Programs. In sum, the contracted agencies serve as the buffers between the providers and the federal government. As a result, all information exchanged between SSA and the individual hospital flows first to the appropriate fiscal intermediary or

state agency or PSRO. In the case of the PSRO, disclosure policies have not yet been promulgated.*

State Agencies

The Secretary of DHEW enters into agreements with the individual states under which the state health or human resources department agrees to determine for SSA whether prospective providers of service meet the conditions for participation in Part A of Medicare. Providers who meet the conditions are certified by the Secretary of DHEW on the basis of the state agency's recommendations. The certification process and the special provisions for hospitals accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) are discussed in Section 1 of Appendix B to this report.

The designated agencies are reimbursed for the cost of the activities they perform for the Medicare program including related costs of administrative overhead and staff. These activities include the provision of consultative services to hospitals to assist them in qualifying as a Medicare provider and the identification of nonparticipating hospitals that can be reimbursed under the Medicare program for emergency services. For non-JCAH accredited hospitals, the state agency conducts field surveys of the providers to determine whether they meet the conditions for participation in the program and periodic resurveys of participating providers to determine whether they continue to meet such conditions. For JCAH accredited hospitals, the stage agency is responsible for determining whether the utilization review requirements of the conditions for participation have been met. In addition, the designated state agency is responsible for coordinating its activities under Medicare with the activities of the state Medical Assistance programs.

* For a discussion of PSRO information disclosure, see Alan Strasser, Disclosure of PSRO Information to Hospital Rate Setting Bodies: A Legal Analysis, another working paper in this series.

Fiscal Intermediaries

Section 1816 of the Social Security Act (42 U.S.C. § 1395 h) provides for the use of public agencies or private organizations to facilitate payment to providers of service. Although the Secretary of DHEW is authorized to enter into agreements for fiscal intermediary services, he does not select the intermediary. Groups of associations of providers, on behalf of their members, nominate a private or public agency to serve as intermediary between them and the federal government.

Although providers also have the option of dealing directly with SSA, almost all providers have elected to deal through intermediaries. Five commercial health insurance companies and the national Blue Cross Association with subcontracts to seventy-three local Blue Cross plans function as the fiscal intermediary for most of the seven thousand Medicare providers. The Division of Direct Reimbursement of SSA handles claims processing for approximately 250 providers, including the federal and most of the state and municipal hospitals.

The fiscal intermediary is responsible for processing the claims submitted by providers for services rendered to beneficiaries under Part A of Medicare. Interim payments are made to the providers on a monthly or more current basis. Annually, the fiscal intermediary is responsible for making a determination on the basis of the provider's annual cost report of the "reasonable cost" for services provided under Part A to Medicare beneficiaries by that provider. Based on this determination, the intermediary pays the provider the amount owed to it or requires the provider to reimburse the Medicare program for any overpayments.

In addition to the claims processing and payment functions, the intermediary's duties include:

- providing consultative services to assist providers to maintain necessary fiscal records and otherwise qualify as providers, and
- serving as a center for, and communicating to providers, any information or instructions furnished by SSA.

Assistance is to be provided to those providers experiencing difficulty implementing utilization review procedures. The fiscal intermediary is also responsible for making audits of provider records and verifying the cost report and billing data.

Professional Standards and Review Organizations

Professional Standards and Review Organizations (PSROs) were created under the authority of Section 249F of the 1972 Amendments to the Social Security Act (P.L. 92-602, 42 U.S.C. § 1320c). The Secretary of DHEW was authorized to designate PSRO areas throughout the country by January 1, 1974. These areas have now been designated and generally include a minimum of three hundred practicing physicians. Participation in a PSRO is to be voluntary and open to all licensed physicians and osteopaths.

According to the Council on Medical Service of the American Medical Association, as of December 1975, 63 conditional PSROs and 58 planning-stage PSROs had been funded by DHEW.* In practice, a PSRO will generally be an organization of practicing physicians. When a PSRO becomes operational, it has the responsibility for determining whether the care and services rendered to beneficiaries of Medicare, Medicaid, and Maternal and Child Health programs were medically necessary and provided in accordance with established professional standards. As part of its responsibilities, the PSRO is required to regularly review provider and practitioner profiles of institutional care to evaluate the necessity, quality and appropriateness of services for which Medicare or the related programs will pay. PSROs are also given the responsibility for advance approval of the medical necessity of all elective admissions to hospitals. However, this approval

* American Medical Association, "PSRO Controversy Heating Up Again," American Medical News, December 15, 1975, pages 1, 11, and 12.

only determines whether Medicare or the related programs will pay for the services, not whether the patient can be admitted. The PSRO can also delegate this function to an in-house hospital utilization review committee when the in-house review is determined to be "effective." Since all PSROs are not yet in full operation, their administrative function and their relationship with other Medicare administrative units cannot be assessed at this time (July 1976).

REFERENCES: APPENDIX A

Appendix A is based on Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 et seq.) the related regulations, government documents, and discussions with staff of the Social Security Administration of the Department of Health, Education and Welfare in Baltimore Maryland. The individuals interviewed and the references consulted are listed below.

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APPENDIX B: PROVIDER REIMBURSEMENT UNDER MEDICARE PART A

[The information on which this appendix is based was current as of January 1976.]

APPENDIX B: PROVIDER REIMBURSEMENT UNDER MEDICARE PART A

The administrative procedures and requirements described in this appendix specify the data necessary for the administration of the Medicare program. The Medicare information system described in the text is a by-product of the administrative process described herein.

Title XVIII of the Social Security Act and the regulations promulgated by the Secretary of DHEW to implement the statute specify the means and manner by which providers will be reimbursed for services rendered to Medicare beneficiaries. "Providers" of service under Medicare are hospitals, skilled nursing facilities, and home health agencies whose services are covered by Part A of Medicare.*

In order to be reimbursed for services rendered to Medicare beneficiaries, a hospital must be approved as a Medicare provider and certified as eligible for said services. The certification requirements and process are explained in Section 1 of this appendix. Reimbursement to providers is made on the basis of reasonable costs determined in accordance with the principles outlined in the statute and further refined in regulations. These principles are discussed in Section 2 and the methods used to achieve the determination of reasonable costs in accordance with these principles are discussed in Section 3. Finally, Section 4 provides a brief description of the Medicare Part A payment process commencing with the individual beneficiary claim and concluding with the settlement of the provider's annual cost report.

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* Physicians, independent laboratories, and others covered by Medicare Part B are not considered providers. For purposes of this report, the term provider will generally be used to refer primarily to hospitals.

Section 1: The Certification Process

The Medicare statute requires hospitals to apply for participation in the program and to be in compliance with the conditions of participation enumerated in the statute and regulations. This certification process was mandated by Congress to insure the health and safety of beneficiaries by preventing dangerous hospitals from participating in the program.

In order to participate as a hospital in the Medicare program, an institution must be a hospital within the meaning of Section 1861 (e) of the Social Security Act (42 U.S.C. § 1395 x). The conditions used to define the term "hospital" are the conditions for participation in the Medicare program and are to be met by all certified providers. To comply with these requirements, the institution must:

(1) be primarily engaged in providing, by or under the supervision of physicians, to inpatients

  (a) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

  (b) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintain clinical records on all patients;

(3) have bylaws in effect with respect to its staff of physicians;

(4) have a requirement that every patient be under the care of a physician;

(5) provide 24-hour nursing service rendered or supervised by a registered professional nurse, and have a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1976, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse

must be present on the premises to render or supervise the nursing service provided during at least the regular daytime shift), where immediately preceding such one-year period he finds that --

(a) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(b) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals and

(c) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) have in effect a hospital utilization review plan which meets the requirements of the law;

(7) in the case of an institution in any state in which state or applicable local law provides for the licensing of hospitals,

(a) be licensed pursuant to such law or

(b) be approved, by the agency of the state or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) have in effect, for fiscal years of the provider beginning after March, 1973, an overall plan and budget, including an annual operating budget and a three-year capital expenditures plan; and

(9) meet any other requirements the Secretary of DHEW finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

[Section 1861(e) of Social Security Act]

These conditions represent essential functions to be performed by the hospital and its staff in order to satisfy the participation requirements related to the quality of care and adequacy of the services and facilities which the hospital provides. It is understood that variations in the type and size of hospitals and the nature and scope of services

offered will be reflected in differences in the details of organization, staffing, and facilities. However, the test is whether there is substantial compliance with the standards developed for each of the conditions. These standards can be found in subpart J, C.F.R. 405.10001 to 405.1040.

When a hospital initially requests permission to participate in the Medicare program and annually thereafter, the hospital submits an application for certification to SSA. This application form, SSA 1514 or the "Hospital Request to Establish Eligibility in the Health Insurance for the Elderly Program," contains basic information on the hospital's bed size, type of control, licensure status, scope of services, and staffing pattern. A copy and description of this form can be found in Section 2 (Provider of Service Record) in Part II of this report.

The application for participation is submitted by the provider to the state agency under contract from SSA to conduct the certification surveys for Medicare to determine whether the institution meets the statutory definition of a hospital and is eligible for reimbursement. This function is generally given to the state health department. The state agency transmits to the Secretary of DHEW its findings as to whether the facilities and services of the hospital substantially meet the conditions of participation. The Secretary uses the state agency findings to determine whether or not the institution is a hospital eligible to be certified as a provider of Medicare services.

The stage agency follows two sets of procedures in determining whether a hospital is in substantial compliance. The statute specifies that hospitals accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) or by the American Osteopathic Association will be deemed to meet the certification requirements of Medicare and need not be surveyed by a state agency except to determine whether the hospital has established a utilization review (UR) plan and has a written overall capital expenditures plan and operating budget. It should be noted that the capital expenditures plan requirement only means that the hospital must have a written document

to show the reviewers. SSA does not keep a copy of this plan or check to see if the plan is followed. If the hospital is JCAH accredited and meets these additional requirements, it is automatically deemed certified and eligible for reimbursement as a Medicare provider. The majority of the hospitals participating in Medicare are deemed certified by reason of their JCAH accreditation. According to the Division of State Operations of SSA's Bureau of Health Insurance, of the 6,300 hospitals eligible for participation in 1973, 4,100 were JCAH accredited and 2,200 non-JCAH accredited, and, by 1975, of the 6,680 eligible hospitals, 4,900 were JCAH accredited and 1,780 non-JCAH.

The majority of the non-JCAH accredited hospitals are small institutions, often with fewer than 25 beds. Because these institutions are non-JCAH accredited, the state agency must perform a complete on-site compliance survey for each institution. On the basis of this survey, the hospital is given a 7A, B, or C certification status or denied certification (7D). A 7A certification means the hospital meets the specific statutory requirements of Section 1861(e) and is found to be operating in accordance with all conditions of participation with no significant deficiencies. A 7B or 7C certification means the hospitals meet the specific statutory requirements but is found to have deficiencies with respect to one of more of the conditions of participation that it is making reasonable plans and efforts to correct. One serious weakness of the Medicare certification process has been its failure to enforce the correction of deficiencies identified during the survey process. In many cases, these deficiencies are merely restated each year when the survey is redone with no effort to require changes be made by a given date or certification will be withdrawn. This is due, in part, to the sensitive political nature of terminating a provider. In addition, many of the poorer hospitals are located in rural areas where they serve as the sole source of care; terminating such facilities could leave Medicare beneficiaries without access to inpatient hospital services.

After the state agency has made its determination, the certification

and transmittal notice (SSA-1539) is completed and a copy is forwarded to SSA in Baltimore and to the appropriate DHEW regional office. This notice, reproduced and described in the Provider-of-Service Record section in Section 2 of Part II of this report, provides SSA with the results of the state agency survey of non-JCAH hospitals and the utilization review and institutional planning survey of JCAH accredited hospitals.

After the receipt of this notice, SSA certifies the hospital as a provider under Medicare and enters into a Health Insurance Benefits Agreement with the hospital. SSA then notifies the appropriate intermediary that the provider is certified and therefore eligible for reimbursement. Annually, SSA prepares a directory listing the name and address of all providers certified under Medicare by state.

The providers are required to file a new certification application with SSA each year to update Medicare records. The state agency survey process need only be done every two years. In cases where hospitals have not met the conditions of participation but are located in areas where no other medical services are available, on the recommendation of the state agency, these hospitals may be approved as providers of service. Resurveys of such hospitals are to be made at least annually. In addition, institutions which have not been determined as being in compliance with all the conditions or which have not applied for acceptance as a participating agency may be paid under the program for emergency services furnished to Medicare beneficiaries.

Section 244 of the 1972 amendments to the Social Security Act (42 U.S.C. § 1395 aa) altered the role of JCAH accreditation in two ways. First, the restriction that the Secretary of DHEW could not set standards that were higher than comparable JCAH requirements was removed. Second, the Secretary of DHEW was authorized to arrange for state certifying agencies to survey JCAH accredited hospitals on a selected and limited sample basis and on a special basis when DHEW receives a substantial allegation with evidence of a condition significantly adverse to patient

health and safety. This provision was enacted in response to concern by consumer advocacy groups over the almost blanket delegation of authority over hospital standards to a private agency, and provides a mechanism for reviewing and assessing the effectiveness of the JCAH survey process. The extent to which deficiencies exist in the participating hospitals deemed certified by reason of their JCAH accreditation can now be determined. If deficiencies from JCAH standards are found to exist in the hospital, the deemed status is revoked and the hospital must apply for recertification after a survey by the state certifying agency assesses whether the deficiencies have been corrected. The validation surveys are to be conducted annually for approximately 200 providers. The first annual survey was completed in the spring of 1975, and the second is currently underway. Of the 105 hospitals reviewed in the first round of validation surveys, 68 hospitals were found to be out of compliance with 65 of those being cited for life and safety code violations.

Section 2: Medicare Principles of Reimbursement

The certified Part A provider under Medicare is reimbursed on the basis of "reasonable cost" as determined under the principles established in the statute and regulations. In general, providers are to be reimbursed for actual costs when incurred even if these costs vary among institutions, unless one institution's costs are substantially in excess of the costs of a similarly situated institution. Unless the provider elects to deal directly with SSA, intermediaries are used to determine the amount of payments owed to or due from providers, to consult with providers relating to cost and other information, and to reimburse providers for their reasonable costs.

Section 1861(v) of the Social Security Act (42 U.S.C. § 1395 x) establishes a general definition for reasonable costs:

> (v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed

> health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services.

The provision excluding costs found to be unnecessary in the efficient delivery of needed health services was added by Section 223(a) of P.L. 92-603 (42 U.S.C. § 1395 x).

The statute gives the Secretary of DHEW broad discretionary power to issue the regulations to implement the act. However, the statute requires that the Secretary take into account both the direct and indirect costs of providers to insure that the costs for Medicare beneficiaries are not borne by other individuals and that the costs with respect to individuals not covered are not borne by the Medicare program. The law also requires that the regulations provide for making retroactive corrective adjustments if the total reimbursement to a provider proves to be either inadequate or excessive. In prescribing the regulations, the Secretary is required to consider the principles generally applied by national organizations or established repayment organizations in computing the amount of payment.

The regulations issued by the Secretary to implement the broad principles of the statute can be found in subpart D, 20 C.F.R. Section 405.401 - 405.499. The regulations are further amplified by the Provider Reimbursement Manual (HIM-15) and the Hospital Manual (HIM-10) which are prepared and published by the Social Security Administration. Changes, corrections, and refinements of the manuals are contained in the Intermediary Letters (ILs) which are issued by the Social Security Administration on an as-needed basis.

As stated above, the primary principle underlying the Medicare provider reimbursement system is that payments to providers under Medicare are to be based upon the reasonable cost of services which are covered by the program and directly related to the care of Medicare beneficiaries. The determination of reasonable cost is done retroactively and is to include all necessary and proper expenses incurred in the production of services related to patient care and including normal stand-by costs. The statute requires that

recognition be given to both direct costs, such as patient's room and board, and indirect costs, such as depreciation, interest on indebtedness, bad debts incurred by Medicare patients, administrative costs, and premium payments for employee fringe benefits.

Excluded Services. Some costs that may be associated with care given to a Medicare beneficiary are specifically excluded from Medicare reimbursement by the statute (42 U.S.C. § 1395 y). These exclusions include:

(1) services deemed not reasonable and necessary for diagnosis or treatment of illness or injury

(2) "custodial services" defined as services designed essentially to assist the patient in meeting his daily activities of living, such as bathing or dressing

(3) services connected with the care, treatment, filling, removal or replacement of teeth or supporting structures

(4) services for treatment of flat feet, sublaxations of the foot or routine foot care

(5) cosmetic surgery

(6) charges imposed by relatives

(7) orthopedic shoes

(8) hearing aids or examinations for hearing aids

(10) services which constitute personal comfort items, such as telephone service or television rental

(11) eye glasses or eye examinations for fitting glasses

(12) services provided outside the United States

(13) services required as a result of war

(14) services for which the individual has no legal obligation to pay

(15) services for which a government agency pays, such as chest x-rays available free from county or city health departments

(16) services covered by workmen's compensation.

It should be noted that while most of these exclusions are fairly specific, the first two provisions which exclude medically unnecessary care and custodial care from reimbursement are subject to broad interpretation.

Ceiling Limits on Costs. The 1972 Amendments to the Social Security Act (P.L. 92-603) set forth additional guidelines for determining providers' reasonable costs under Part A, Section 223 (42 U.S.C. § 1395 x), which authorizes the Secretary of DHEW to set limits on costs recognized as reasonable under Medicare for comparable facilities in the same or a similar service area. Congress's intent in enacting this section was to exclude from Medicare reimbursement "costs estimated to be in excess of those necessary in the efficient delivery of needed health services." In other words, hospitals with higher costs attributable to inefficiency or the provision of amenities and plush surroundings were no longer to be reimbursed for these higher costs. To implement this section, the Secretary of DHEW published a "schedule of limits on hospital inpatient general routine service costs" effective for cost reporting periods beginning on or after July 1, 1974. For 1974, the hospitals were grouped by per capita income of the state in which they were located, urban/nonurban location, and bed size. A per diem limit was placed on the level of reasonable cost for each hospital group, beyond which the component hospitals' routine costs were not recognized as reimbursable. For cost reporting periods beginning on or after July 1, 1975, the methodology has been revised to recognize that certain urban areas (SMSAs) within a state may have income levels and related economic characteristics which are significantly different from those of other SMSA areas in the same state. In the revised methodology the SMSA replaces the state as the major geographical grouping factor for urban areas. Nonurban areas continue to be grouped on a statewide basis.

These ceilings are for the hospitals' inpatient general routine service costs and do not cover the ancillary services or special care unit costs. The providers are informed of the cost limits in advance and are allowed to bill the patients for the difference between the cost limit and the lower of cost or charges for the second preceding year. Before the provider can bill the patients for the difference, the intermediary must grant approval and a notice must be published in the newspaper. In addition, the patient must be informed of this additional charge prior to

admission, the services provided must not be considered emergency care, and the admitting physician must not have a financial interest in the institution.

The congressional purpose for this amendment is generally recognized as legitimate and necessary. However, the methods used by DHEW in the regulations to group hospitals and set cost limits are viewed by many as crude and unfair. The courts are now being asked to decide if these regulations and the methods for determination of cost ceilings prescribed therein violate the statutory intent.

Lesser of Costs on Charges. Section 233 of P.L. 92-603 (42 U.S.C. § 1395 f) placed another limitation on reasonable costs by establishing the requirement that for all cost-reporting periods beginning after December 31, 1973 (originally 1972, but revised to 1973), a provider will be paid the lesser of the reasonable costs of providing the services (as determined by Medicare Principles of Reimbursement) or the customary charges with respect to such services (as determined by the hospital's charge schedule or the most frequently used charge for a specified service that is actually collected from a substantial number of patients). This provision was enacted to remedy cases in which Medicare was paying higher amounts under the reasonable cost determination for services received by Medicare beneficiaries than would have been charged if the beneficiary were not on Medicare. This provision does not apply to public providers (city hospitals) who generally furnish services free or at a nominal fee. In comparing reasonable costs to reasonable charges under this section, the aggregate costs of both Parts A and B are compared to the aggregate charges of the institution instead of merely looking at Part A costs under Medicare. As might be expected, this provision offered a powerful incentive to providers to revise their charge schedules upward before December 31, 1973.

Limitations on Capital Expenditures. To avoid the use of federal funds to support unjustified capital expenditures and to support health facility and health services planning in the various states, Section 221 of P.L. 92-603 (42 U.S.C. § 1320a-1) authorizes the Secretary to withhold or reduce Medicare reimbursement for depreciation and interest on capital expenditures in excess of $100,000 that have not received the approval of the state or local planning agency. In the case of proprietary providers, the return on equity capital related to the disallowed capital expenditure can also be withheld. This provision is only in effect in those states under contract with DHEW to conduct reviews of capital expenditures. As of October 1975 thirty-nine states were under contract. This review process is often referred to as "Section 1122 Reviews" because Section 221 of P.L. 92-603 became Section 1122 of the Social Security Act.

Allowable Costs. In addition to these general principles of reimbursement contained in the statute, the Medicare regulations and supplementary manuals (such as the Provider Reimbursement Manual HIM-15) further specify what costs will be considered allowable under Part A of Medicare. These allowable costs include:

(1) depreciation

(2) interest

(3) bad debts incurred by Medicare patients (other bad debts are not allowable)

(4) the net costs of approved educational training programs for medical students, interns and nurses

(5) research costs which are incurred in direct connection with patient care and are not covered by a separate research grant

(6) the value of service of nonpaid workers in positions normally held by full-time workers

(7) the compensation of owners when the owner performs services necessary to the functioning of the hospital

(8) the cost paid to related organizations for provision of services

(9) for proprietary institutions, return on equity capital used in providing care to Medicare beneficiaries.

The regulations define the conditions for inclusion of these costs in the reimbursement formula.

Depreciation is an allowable cost only when it is identifiable and recorded in the hospital's accounting records, based upon the historical cost of the asset at fair market value or of a donated asset at the time of donation and prorated over the estimated useful life of the asset. All necessary assets used in providing services to Medicare beneficiaries are recognized even if they were fully or partially depreciated at the time of the hospital's initial participation in the Medicare program. After August 1, 1970, depreciation had to be computed using the straight line method for assets acquired on or after that date.

Depreciation as an allowable cost has been the subject of much controversy. Disputes often arise over:

(1) the amount of loss or gain to be recognized on the disposition of assets;

(2) the point in time at which to commence depreciation on a new wing (i.e., date when construction begins or date when the first patient is admitted);

(3) the determination and change of assets "useful lives";

(4) the determination of the basis for depreciation of assets acquired from a prior provider; and

(5) the recognition of depreciation on facilities leased by the provider for a nominal value.

Interest incurred on capital and current indebtedness is considered an allowable cost if it is "necessary" and "proper". "Necessary" is defined as interest on a loan made to satisfy the provider's financial need and for a purpose reasonably related to patient care, and "proper" is defined as interest at the rate that a prudent buyer would pay in the marketplace. In other words, the provider must use available funds before Medicare will reimburse it for interest on borrowed funds. Interest is not an allowable cost when it is paid to a lender who is related to the borrower through ownership, control or personal relationship.

Bad debts, charity and courtesy allowances are considered deductions from revenue and are not allowable costs. The only exception is that bad debts that are incurred by Medicare beneficiaries from failure to pay the co-insurance and deductible amounts are reimbursable. Controversy in this area has arisen over the disallowance of Medicare bad debts based on an alleged failure in the provider's collection efforts and the failure of Medicare to recognize Hill-Burton free services as an allowable cost analogous to interest expense. Since the Hill-Burton free care provision requires hospitals to furnish uncompensated services to indigents equivalent to ten percent of the Hill-Burton grant per year for twenty years (i.e., for every $100,000 borrowed, the provider is expected to provide $200,000 of free service in twenty years), hospitals claim that an "interest expense" has been paid on the $100,000 of care provided above the amount of the grant which should be recognized as an allowable cost of patient care.

Grants, gifts and income from endowments that are unrestricted are not deducted from operating costs when computing reimbursable costs. Restricted gifts which are earmarked for specific operating expenses are deducted. Controversies in this area have arisen over the disallowance of the inputed costs of supplies donated to a provider or the reduction of allowable costs by the amount of grants intended to compensate the provider for operating deficits when the amount of the grant was measured in terms of anticipated operating expenses. To eliminate this area of controversy, most hospitals now ask donors to specify that their gift is for capital purposes and therefore not to be used to reduce allowable costs.

Discounts and allowances on the purchase of goods or services are deducted from the gross amount paid in determining allowable costs. On the other hand, if a discount is available and the provider does not take advantage of it, the intermediary may disallow the excess cost of such items when computing allowable costs. The fine line between a rebate and a charitable contribution has been the subject of much controversy in this area.

When Medicare was first established, DHEW agreed to pay providers

a 2 percent plus factor for unspecified costs and issued regulations to implement this agreement. However, in response to Congressional criticism, the 2 percent plus factor was eliminated as of June 30, 1969. In its place, DHEW instituted the 8.5 percent inpatient nursing salary cost differential in recognition of the hospitals' contention that the elderly required above average cost inpatient routine nursing services. On April 17, 1975, the Secretary of DHEW promulgated new regulations to terminate the nursing differential. However, there are current attempts, both in the courts and in Congress, to restore this differential to providers.

Based on the principles outlined above and enumerated in the law and regulations, the fiscal intermediaries and/or the Social Security Administration make determinations of "reasonable cost" for each provider and reimburse them accordingly. To accomplish this determination, the intermediary or SSA uses the provider's annual cost report to separate allowable from nonallowable costs and to determine the share of total costs which are attributable to Medicare patients using the processes of cost-finding and cost apportionment. These processes are explained in the next section.

Section 3: Cost Finding and Apportionment of Costs

Since the statute requires that the Medicare program only pay for the proportion of allowable costs that is attributable to Medicare beneficiaries, the hospital's allowable costs must be apportioned between Medicare beneficiaries and other patients, by either the departmental or combination method of cost apportionment. The regulations currently require hospitals with 100 or more beds to use the departmental method of cost apportionment with stepdown, double distribution, or a more sophisticated method of cost finding; hospitals with under 100 beds use the combination method of cost apportionment, with the simplified method of cost-finding. Each of these methods is briefly described below.

Cost-Finding. Cost-finding is the process of allocating the costs of the non-revenue producing centers (i.e., support or overhead units that provide necessary services to other hospital departments, such as laundry, maintenance, cafeteria, administration, etc.) to each other and to the revenue-producing centers (i.e., departments providing direct service to patients and thereby generating revenue such as X-ray, laboratory, pharmacy, etc.) on the basis of statistical data that measure the amount of service rendered by each cost center to the other cost centers. As will later be explained, when using the simplified method of cost-finding, the costs are only allocated to the revenue-producing centers. The purpose of cost-finding is to determine the total or full costs of operating the revenue-producing centers of the hospital. Once determined, these costs can then be apportioned between Medicare beneficiaries and all other patients using either the departmental or combination method of cost apportionment.

There are two basic methods of cost-finding used by Medicare: the simplified method and the step-down method. It is also possible to use the double distribution method or a more sophisticated method, but approval must be obtained from the intermediary beforehand. For cost reporting periods beginning on or after January 1, 1972, all hospitals with less than 100 beds have been required to use the simplified method of cost-finding. Hospitals with short cost report periods between January 1, 1972, and May 20, 1972, were exempted from this requirement until after May 20, 1972. With this method, costs of nonrevenue-producing centers are allocated only to the revenue-producing centers. The fact that most nonrevenue-producing centers also render services to other nonrevenue-producing centers is ignored.

Hospitals with 100 or more beds are required to use the step-down method of cost-finding or the double distribution or a more sophisticated method. Under the step-down method, the accumulated cost of the nonrevenue producing centers is allocated to the other nonrevenue-producing centers as well as to the revenue-producing centers. Once the costs of a non-

revenue producing center have been allocated, that center is considered closed and will not receive costs from other non-revenue producing centers not yet closed. Therefore, the first center closed should be the one that renders the greatest amount of service to the largest number of centers and receives the least amount of service from the fewest centers (i.e., depreciation, employee health and welfare benefits, etc.). While the step-down method is more accurate than the simplified method, it still does not produce the total costs of operating the revenue producing centers. The double distribution method is more sophisticated than the step-down method because it gives greater recognition to the provision of services by non-revenue producing centers to other non-revenue producing centers. Under this method, non-revenue producing centers are not permanently closed after their costs have been allocated, but are reopened to receive cost allocations from other non-revenue producing centers. The first allocation is followed by a second allocation of expenses in which all costs remaining in the non-revenue producing centers are allocated and the centers are then closed.

Worksheets A and B of the Cost Report for hospitals with over 100 beds and the attendant worksheets are the forms used by Medicare providers to calculate the amount of reimbursement due from Medicare. On Worksheet A, the accounting and statistical data from the hospital's general ledger and from departmental statistical reports is collected and reported in appropriate columns. Preliminary reclassifications and adjustments are made to the trial balance. On Worksheet B, the costs of non-revenue producing centers are allocated to the revenue producing centers by one of the cost-finding methods described above. As a result of this cost-finding process, the total costs for each revenue producing department are determined for use in the cost apportionment process.

Cost Apportionment. Cost apportionment is the process of determining what proportion of allowable costs is attributable to Medicare beneficiaries as distinct from other patients. For cost reporting periods beginning after

January 1971, hospitals with under 100 beds are required to use the combination method of cost apportionment coupled with the simplified method of cost-finding described above. Hospitals with 100 or more beds are required to use the departmental method of cost apportionment with either the step-down or the double distribution (or a more sophisticated) method of cost-finding. Under the departmental method of cost apportionment, also known as RCCAC (Ratio of Charges to Charges Applied to Costs), the ratio of beneficiary charges to total patient charges for the services of each ancillary department is computed and applied to the cost of each ancillary department. The Medicare share for individual ancillary departments is totaled and added to the cost of routine services for beneficiaries. The routine service cost is determined on the basis of a separate cost per diem for general routine patient care areas and a separate average cost per diem for each intensive care unit, coronary care unit, and other special care inpatient hospital units.

The combination method does not require the specificity of the departmental method and thus was designed for use by hospitals with less sophisticated accounting systems. Under this method, the cost of routine services for beneficiaries is determined on the basis of a separate average cost per diem for general routine patient care areas and, in hospitals, a separate average cost per diem for the aggregate of intensive care, coronary care, and other special care inpatient hospital units. To this amount is added the cost of ancillary services used by beneficiaries, determined by apportioning the total cost of ancillary services (excluding delivery room costs) on the basis of the ratio of beneficiary charges for ancillary services to total patient charges for such services (excluding charges for the delivery room). As a result of the extension of Medicare coverage to the disabled under the 1972 Amendments to the Social Security Act (P.L. 92-603), delivery room costs are now separately apportioned to account for delivery room use by the disabled. Renal dialysis costs are also separately apportioned to account for the high utilization of such services by Medicare beneficiaries.

Since the regulations that are currently in force require all

providers with less than 100 beds to use the combination method of cost apportionment and the simplified method of cost-finding, for purposes of simplicity, all future references to the combination method will imply cost-finding to be done by the simplified method. Similarly, all references to the departmental method of cost apportionment will imply use of the step-down method of cost-finding or some more sophisticated method.

However, it should be noted that in October 1975 the requirement that hospitals with under 100 beds use the combination method with simplified cost-finding was being reconsidered by the Bureau of Health Insurance (BHI) and possible elimination of this requirement was anticipated. As previously noted, the simplified cost finding method is not as refined as the step-down method and therefore does not require as sophisticated a level of accounting. When Medicare was first implemented in 1965, the smaller hospitals complained that the step-down method of cost-finding was too complex and that they did not have the accounting capability to use this method of cost-finding. After much agitation and on the recommendation of DHEW Audit, the Government Accounting Office (GAO) and the Senate Finance Committee, BHI changed the cost-finding requirements and required the smaller hospitals to use the combination method with simplified cost finding instead of step-down cost-finding for all accounting periods beginning on or after January 1, 1972.

As discussed above, the simplified method of cost finding only uses five groupings of overhead costs and allocates these directly to the revenue producing centers. The five groupings are:

1) depreciation, operation, plant maintenance and housekeeping
2) employee health and welfare
3) dietary and cafeteria
4) nursing, intern and resident service
5) other general service cost centers.

Because of lack of detail, the simplified method is not very accurate as a means of allocating costs since the costs of many non-revenue

producing centers are allocated to revenue producing centers that do not require those services. For example, laundry costs are included in grouping one (depreciation, operation, plant maintenance and housekeeping) and are therefore allocated to the pharmacy along with depreciation and other housekeeping costs even though the pharmacy does not utilize laundry services. As a result, many small hospitals now recognize that the combination method with simplified cost-finding is providing them with a lower level of reimbursement than would be obtained by using the departmental method with step-down cost finding. Therefore, many smaller hospitals have recently begun to complain that they are being inequitably treated by being required to determine Medicare reimbursable costs in this manner.

In January 1975, to determine whether the regulations governing the methods of apportionment and cost-finding for hospitals under 100 beds and Skilled Nursing Facilities (SNFs) should be revised, BHI surveyed the intermediaries and a sample of hospitals and SNFs. The purpose of the survey was to ascertain whether these facilities were capable and willing to transfer to the departmental apportionment method using step-down cost finding. As a result of this study, BHI determined that over 95 percent of the hospitals with less than 100 beds were capable of computing reimbursement using the departmental method and step-down cost-finding and more than 60 percent were willing to transfer to such methods. There was no difference in the hospital's capability based on bed size or type of control. On July 23, 1975, a letter was sent from the accounting section of BHI to all intermediaries and the American Hospital Association informing them of the results of the BHI survey and alerting them to the fact that BHI was giving thought to the elimination of the combination method for hospitals with under 100 beds.

In January 1976, the Director of the Bureau of Health Insurance decided to retain the combination method of cost apportionment for skilled nursing facilities and hospitals with under 100 beds. However, the matter is still subject to reconsideration in the future.

Section 4: The Payment Process

After a hospital has been certified as a participating provider in the Medicare program, it is entitled to collect payment for the reasonable cost of services rendered to Medicare beneficiaries. The process through which the amount of reimbursement is determined involves several steps: submission of the individual claim form, payment of an interim rate or periodic interim payment, settlement of cost report, retroactive adjustments, reopenings, recoupment of alleged overpayments, and appeals. It is, of course, not intended for each provider to go through all of the steps in the payment process. Ideally, each provider would merely provide services and be paid an interim rate for said services with year-end adjustments and a final settlement made upon submission of the annual cost report. Section 1815 of the Social Security Act (42 U.S.C. § 1395 g) requires that no payment be made to a provider unless it has furnished whatever information the Secretary requests to determine the amount due to the provider.

The cost report is a series of worksheets prepared annually by each Medicare provider and used by the fiscal intermediaries to determine the amount of reimbursement due to the provider for services rendered to Medicare beneficiaries. After the intermediary conducts a desk review of the cost report to verify the mathematics and the completeness, the hospital receives a tentative payment pending audit and final settlement. Once a final cost settlement has been made, the fiscal intermediary forwards a copy of the audited cost report to the central offices of SSA in Baltimore.

Since the cost report determination of the amount of reimbursement is only done annually, periodic payments are made to providers based on an interim rate which is expected to approximate the costs to be incurred over the annual period. Each time a Medicare beneficiary is admitted and discharged from the hospital, the hospital submits the "Inpatient Hospital and Skilled Nursing Facility Admission and Billing Form" (SSA-1453), to the fiscal intermediary. This billing form is described and reproduced in Section 3 of Part II of this report. However, the intermediary does not pay

the hospital directly for each individual claim. Instead, interim payments approximating the actual costs of the provider are made on a monthly basis. The interim rate is generally based on the provider's cost report for the previous period or, if the provider is new to the Medicare program, on the basis of the costs of a comparable provider. When qualified, providers desiring more frequent payments from Medicare can participate in the Periodic Interim Payment Program (PIP) which provides bimonthly payments on the basis of an interim rate expressed as a percentage of billed charges or average per diem.

At the end of the year, actual costs reimbursable to a provider can be determined through the verification of the cost submitted on the provider's annual cost report. A retroactive adjustment is then made to bring the interim payments made to the provider into agreement with the reimbursable amount payable to the provider for services rendered to Medicare beneficiaries during that period. The cost report is the basis for this year-end adjustment and the final determination of the amount of reimbursement to the hospital from Medicare.

Once the cost report has been submitted to the intermediary, it is subjected to a desk review to verify the accuracy of the data. At that point, the intermediary can either obtain from or pay to the provider a tentative retroactive adjustment payment. This is subject to a later audit and verification before a "final" retroactive adjustment is determined. Any intermediary challenges which have not been resolved by the audit are presented to the provider in the "audit adjustment report" which is discussed by the provider and the intermediary at a post-audit "exit conference." The exit conference is only held if there are differences to be resolved. Following the exit conference, the intermediary finalizes its audit adjustment report. The provider's total allowable cost has now been determined and the intermediary issues a "notice of Program Reimbursement" to the provider which constitutes the basis for making the final retroactive adjustment to any Medicare payments made to the provider.

After final settlement of the cost report, the provider or intermediary can request a reopening or the Bureau of Health Insurance (BHI) may require that the case be reopened. Recently BHI has increasingly reopened intermediary settlements in situations where BHI feels the intermediaries may have been overly favorable to providers. A reopening must take place within 3 years of the "Notice of Program Reimbursement" unless there is suspicion of fraud, in which case there is no time limit. In addition to BHI, the Government Accounting Office (GAO), which is the Congressional audit agency, has recently begun to direct reopenings.

Repayment has been the subject of much controversy between BHI and the providers. One aspect of this controversy concerns the time lag between determination of underpayment (i.e. Medicare owes the provider money) and actual payment to the provider. Long delays result from the BHI policy that a provider cannot be paid until both the intermediary and provider agree on the amount in question. However, when the provider has allegedly been overpaid, the overpayment must be recouped immediately, even if the provider is vigorously opposing the intermediary's determination. In other words, the liability of repayment by the provider arises simultaneously with the discovery of overpayment while SSA/intermediary's liability does not arise until all discussions on the case have been completed and a final determination made.

A second area of contention is the recoupment of alleged overpayments to providers concerns situations arising from an intermediary's determination that services rendered to a beneficiary are not allowable under the Medicare scope of services and thus are not reimbursable. In these cases, the provider can often be left to assume the cost of provision of the non-covered service, the provider can attempt to collect for that service from the beneficiary, if the beneficiary knew it was a non-covered service or from Medicare if neither the provider nor the beneficiary knew it was a non-covered service. However, if the provider knew or should have known that the services were not covered, then Medicare will not pay for the

services and the provider is prohibited from charging the unknowing beneficiary. A provider is assumed to not know it was providing non-covered services if:

1) the provider's claim denial rate does not exceed 10% of the patient days submitted for payment,
2) admission notices and bills have been submitted on a timely basis
3) the provider can show it has an effective and operating utilization review program,
4) the provider has complied with all certification and recertification requirements, and
5) the provider has generally been able to accurately distinguish between covered and non-covered services in accordance with current coverage guidelines.

If the provider is not in compliance with all five of these conditions, the provider is liable for the cost of the non-covered services. The questions of coverage which are the most problematic are those in which reimbursement for services has been denied because the services provided were deemed "not reasonable and necessary" or "custodial care".

The intermediary can suspend payment to the provider if the intermediary has determined that the provider has been overpaid under Medicare or has strong reason to believe that this is the case. The provider must be given fifteen days to file evidence to show why the proposed suspension should not take place. Pursuant to Section 229 of P.L. 92-603 (42 U.S.C. § 1395 cc), payments to a provider can be terminated if the Secretary of DHEW has determined that the provider has knowingly misrepresented a material fact in the application for payment or has submitted bills in excess of customary charges or has furnished services that are substantially in excess of the needs of individuals or are of grossly inferior quality.

If the provider is not satisfied with the settlement determined by the intermediary and the amount in question is in excess of $10,000 for one provider or $50,000 for a group of providers where the dispute concerns common issues, the decision can be appealed to the Provider Reimbursement Review

Board of DHEW. The appeal may be made on the grounds that the intermediary's final determination was not reasonable or because the intermediary failed to make a "timely" determination. If the Secretary of DHEW reverses the decision of the board, the provider has the right to judicial review review (Section 243 of P.L. 92-603, or 24 U.S.C. § 1395 oo). The estimated costs of an appeals hearing including the factual and legal research and submission of appropriate papers is $7,000 - $20,000 for the provider. If the process goes to the Federal District Court Review, it could cost the provider another $5,000 - $15,000. However, it should be noted that both attorney and accountant fees reasonably incurred in resolution of Medicare controversies are included in the reimbursement formula as an allowable cost.

APPENDIX B: REFERENCES

Appendix B is based on Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 et seq.) the related regulations (20 C.F.R. §§ 404 et seq.), selective readings, and discussions with staff of the Social Security Administration on the U.S. Department of Health, Education and Welfare in Baltimore, Maryland. The references consulted and individuals interviewed are listed below.

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APPENDIX C: COMPARISON OF OLD AND NEW MEDICARE COST REPORTS FOR HOSPITALS WITH A HUNDRED OR MORE BEDS

[The table that follows provides an item by item comparison of the old and new cost report packages. The method used in compiling the table was to take each item in the new cost report and attempting to find a comparable item in one of the forms comprising the old cost report package. Failure to locate a comparable item was noted. Items appearing in the old reports but not present in the new were also noted. The comments column of the table points out significant differences between the two report packages.]

Appendix C: Comparison of Old and New Medicare Cost Reports
For Hospitals with 100 Beds or More

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Part I General Information	SSA - 2570		
	Hospital name; address, provider number; type of control; type of hospital, certification date; name of sub-provider, extended care facility, or home health agency	Same with addition of item indicating whether hospital is a certified kidney transplant hospital	Certification statement included; uses stronger verbage in fraud statement; will be used for Titles 18, 19, and 5.
Part II Hospital Statistics	SSA - 2570		
	Lists by general service, special care, subprovider, and ECF: the number of beds, bed days, total inpatient days, discharges and admissions; the % occupancy; and the average length of stay. This is done for all patients, for Title V patients, for Title XVIII patients, and for Title XIX patients. Lists number of occasions of outpatient service.	More detail requested - uses same categories as SSA - 2570 except special care units broken down into ICU, CCU and other Part II requests statistics for hospital - Part IV for subprovider and SNF - Information requested in Part IV identical to that of Part II. For all patients, requests number of beds; bed days; aged, pediatric, and maternity inpatient days; total inpatient days; newborn days, and percent occupancy. For Title V, inpatient and newborn days. For Title XVIII: inpatient days, kidney acquisition days; Part A inpatient days, Part B inpatient days. For Title XIX: inpatient days and newborn days.	The new cost report reflects addition of disabled to medicare - most of the changes in reporting of statistics elicit new information on renal dialysis and kidney transplants.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Part III Other Hospital Data	SSA - 2570 For hospital, subprovider and extended care facility: the amount of current financing outstanding as of end of cost reporting period, amount of outstanding accelerated payments, average number of employees on payroll, and average number of non-paid workers.	Same information as SSA - 2570 Additional information on: number of renal dialysis treatments, admissions, discharges, and average length of stay for all patients, Title V, Title XVIII and Title XIX patients. Part V requests same information for subprovider and skilled nursing facility.	
CALCULATION OF REIMBURSEMENT			
Worksheet Reclassification of Trial Balance of Expenses (Worksheets described below used to derive figures for Schedule A.)	SSA - 1562 Eliminated 33 categories including administration and general, employee health & welfare, dietary, housekeeping, laundry, x-ray, nursery, emergency services, depreciation, etc. Results in net expenses for each account for cost apportionment. (Replaced by SSA-2570) SSA - 2570 SSA - 2570 instituted in 1972 uses the 70 cost centers incorporated in Schedule A of SSA - 2552.	70 categories used - divided into general service cost centers (depreciation, dietary, pharmacy, etc.), ancillary service cost centers (operating room radiology, etc.), inpatient routine service cost centers (adult & pediatric, ICU, CCU), outpatient service cost centers (clinic & emergency), other reimbursable cost centers (home health agency, ambulance, interest, etc.) and non-reimbursable cost centers (gift shop, research, etc.).	The format (columns for salaries, other direct expenses, total expenses, adjustments, and net expenses for cost allocation) is the same - the difference is that 2552 requires a much more detailed breakdown of cost centers.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet A 1	SSA - 1562		
Reclassification Affecting Administrative and General Expenses (1562 Administrative and General Expenses Analysis)	Provides salaries, other expenses and total expenses for employee health and welfare benefits (personnel department, employee health service, hospitalization insurance, workman's compensation, employee group insurance, social security taxes, annuity premiums), interest and remaining administrative expenses.	Retains all categories listed on 1562 and adds unemployment taxes to employee health and welfare benefits and breaks remaining administrative expenses down into rent, insurance and property taxes. Requires interest, insurance, taxes and rent related to buildings to be reclassified and allocated with depreciation.	Basically unchanged Corrects situation where interest could be allocated on accumulated cost and depreciation on square footage.
A2 Reclassification of Dietary Expenses	SSA - 1562 Value of raw food divided between cafeteria, nursery and other. salaries and other expenses divided between cafeteria and dietary; summary of first two sections.	No breakdown by raw food and other expenses	Slightly different format but basically same
A3 Reclassification of Central Services and Supplies	SSA - 1562 Amount spent on intern resident service, oxygen therapy, and medical supplies and expenses.	Intern and resident service amount in dollars broken down into amount for approved intern and resident service and amount for non-approved intern and resident service; amount in dollars for intravenous therapy.	Increased detail on 2552 reflects increased detail of Schedule A.
A4 Reclassification of Laboratory Expense	SSA - 1562 Salaries and other expenses for blood bank and other laboratory	Total amount in dollars for blood; blood storing, processing, and administration; electrocardiology, electroencephalography; and other.	2552 requires more detailed breakdown of laboratory expenses, but does not request salary-non-salary breakdown of 1562.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
A5 Reclassification of Radiology - diagnostic	Not Included	Amount in dollars for therapeutic radiology, radioisotope, electrocardiology, electroencephalography	2552 - new information
A6 Reclassifications Other	Not Included	Provides space for hospital to include other cost centers	2552 - new information
A7 Limitation on Federal Participation for Capital Expenditures Questionnaire	Not Included	Analysis of changes in capital asset balances of land, land improvements, buildings and fixtures, building improvements, fixed equipment, and movable equipment. Description of each capital expenditure, how acquired, date obligation incurred, cost, depreciation, interest, rent, & other expenses. Date provider submitted notice to planning agency, date approved or disapproved.	This section included in 2552 to provide information for administration of Section 1122
Worksheet A-8	SSA - 1562		
Adjustments to Expenses	This is Worksheet A-5 on SSA - 1562. For 22 categories (such as telephone, radio and television service, vending machines, rental of hospital space, drugs to other than patients, etc.) provides amount in dollars of adjustment and account to which amount is to be deducted or added	Same format as used in 1562, but more detailed categories - 29 categories plus 31 blank sections to allow hospital to include more detailed breakdown.	Basically the same

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet A-8-1			
Statement of Costs of Services from Related Organizations	Not Included	Costs incurred and adjustment required as a result of transactions with related organizations broken down by cost center, expense items, amount in dollars, amount in dollars of allowable cost and net adjustment. Name and % ownership of provider in related organizations, nature of relationship, and type of business.	Note: this section was considered extremely sensitive . . . almost not included for fear of violating Privacy Act.
Worksheet A-8-2	SSA - 1563		
Depreciation	Same as SSA - 2552 but does not include section on computation of adjustment to depreciation on owned assets.	Part I asks if dollar amount of depreciation on straight line, declining balance, sum of years' digits, or optional allowance; if depreciation funded; etc. Part II is computation of optional allowance for depreciation and computation of limitation of the optional allowance. Part III computation of adjustment to depreciation on owned assets broken down into buildings and moveable equipment.	More detail, but same format.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet B Cost Allocation - General Service Costs	SSA-1562 - For Hospitals With 100 or More Beds In the order of allocation: 18 general service cost centers beginning with depreciation, administrative and general, and employee health and welfare. 10 Special Service cost centers (OR delivery room, x-ray, etc.) Inpatient cost centers - first inpatient, then nursery. Outpatient cost centers broken down into outpatients, emergency, and private ambulatory. Not included Not included. SSA-2570 for Hospitals With Less Than 100 Beds Very simplified - depreciation, employee health and welfare,	In the order of allocation: Same 18 categories, but uses slightly different order (e.g. employee health and welfare allocated before administrative and general.) 21 ancillary service cost centers provides more detailed breakdown than 1562. Inpatient routine service cost centers broken down by adult, ICU CCU, nursery and skilled nursing facility. Outpatient service cost centers broken down by clinic and emergency- private ambulatory omitted. Other reimbursable cost centers broken down by home health agency, ambulance service, and non-approved intern and resident service. Non-reimbursable cost centers such as gift shop, private physicians' offices, non-paid workers, etc.	Provides for allocation of general service cost centers to centers which receive the services. SSA-1562 has 34 required cost centers for purposes of allocation and blank spaces for 7 additional categories. SSA-2552 has 61 required cost centers for purposes of allocation and blank spaces for 7 additional categories. SSA-2552 is therefore more detailed than 1562 and breaks out several items recently included under medicare's scope of benefits such as kidney acquisition and renal dialysis. Note: the brief and non-complicated format of SSA-2570 for hospitals with under 100 beds.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Continuation Worksheet B	dietary and cafeteria, nursing-intern-resident service and other general service cost centers. Costs are allocated to the 14 reimbursable cost centers and 2 non-reimbursable cost centers.		
Worksheet B-1 Cost Allocation - Statistical Basis (1562 - Cost Apportionment Statistical Basis)	<u>SSA-1562 - For Hospitals With 100 or More Beds</u> Uses Cost Centers listed in Schedule B of 1562. Statistical bases used: depreciation on buildings - sq. feet depreciation on equipment - dollar value or square feet employee health & welfare - gross salaries operation of plant - sq. feet laundry - pounds of laundry, etc. Bottom line is total cost in dollars to be apportioned for each cost center and the unit cost multiplier for each cost center. <u>SSA-2570 For Hospitals With Less Than 100 Beds</u> After 1972, only hospitals with 100 or more beds used Worksheet B-1 of 1562 - Hospitals with	Uses cost centers listed in Schedule B of 2552 so more detailed than 1562. There has been no change in statistical basis suggested for each cost center. Same bottom line-just with more refined cost centers.	Provides for the proration of the statistical data needed to allocate equitably the expenses of general service cost centers on Worksheet B. General format of Worksheet B & B-1 are identical. Provider is allowed to substitute other bases if they result in more appropriate and accurate allocations. Intermediarys approval must be obtained The order of allocation may be changed at the request of the provider prior to the cost reporting period if different order would be more accurate. Note: the use of SSA-2570 for hospitals under 100 beds after 1972 reflects

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
	under 100 beds used Schedule B-1 of SSA-2570 which simplified the cost allocation process by only using 5 categories: depreciation, employee health & welfare, dietary, nursing & intern-resident service and other general service cost centers.		the change in regulations which required hospitals with less than 100 beds to use the combination method of cost apportionment with simplified cost finding.
For 1562, Worksheet B-1-1, Cost Apportionment - Dietary Raw Food and B-1-2, Cost Apportionment - Dietary - Other)	SSA-1562 Number of meals served attributable to other cost centers and amount in dollars for cost apportionment.	Not Included	This schedule eliminated from 2552.
Worksheet C Departmental Cost Distribution	SSA-1562 For Hospitals With 100 or More Beds Distribution of costs for special cost centers, inpatient cost centers, and outpatient cost centers used in Worksheet B between inpatient, nursery, outpatient, emergency and private ambulatory - Modified in 1972 to include reporting for subproviders & ECFs.	Distribution of costs & gross charges of ancillary service cost centers and outpatient service cost centers used in Worksheet B between hospital, subprovider I, subprovider II, skilled nursing facility, Title XVIII Part B, kidney acquisition, other outpatient, and home health agency. Instead of taking total outpatient costs to total outpatient charges, it is now done on the departmental basis; in	The increased detail for cost distribution on 2552 reflects recent changes in the Medicare scope of benefits (inclusion of kidney acquisition, etc.) as well as the increased level of detail in Worksheet B of 2552. Formerly, departmental cost distribution made on the basis of charges to charges according to costs; now, for simplicity, change computation costs to charges related to charges/

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
	SSA-2570 For Hospitals With Less Than 100 Beds Number of cost centers reduced to radiology, lab, drugs, delivery room, other ancillary, adult inpatient, pediatric, special care units, nursery, ECF, and outpatient. The expenses for these cost centers are distributed between hospital inpatient, subprovider, ECF, or Home Health Agency.		
Schedule C-1	SSA-1562 For Hospitals With 100 or More Beds Schedule C-1 uses same cost centers as Schedule C and requests total gross charges by cost center for all patients and then broken down by inpatients, nursery, outpatients, emergency and ambulatory. SSA-2570 For Hospitals With Less Than 100 Beds Using cost centers in Schedule C, the total gross charges are distributed by cost center according to the estimated percentage of patient services.	Includes column for ratio of costs to charges.	2552 combines the separate Schedule C and C-1 of 1562 into one Schedule C.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
	SSA-1562	SSA-2552	
Cost Per Unit of Service	Schedule D - Cost per unit of service Gives total costs, number of services rendered, and average cost per unit of special service cost centers, inpatient cost centers, and outpatient cost centers	This schedule not included in 2552	The cost per unit of service eliminated from SSA-2552 so there is no longer a schedule which supplies number of films for x-ray, number of transfusions for blood bank, etc. Statistics such as number of nursery and inpatient days are provided in the statistical section of SSA-2552.
Worksheet D Apportionment of Inpatient Ancillary Services to Health Care Programs	not included	For each of the ancillary and outpatient service cost centers, health program inpatient changes and health care inpatient expenses are broken down by dollars for Title V, Part A Title XVIII, Part B Title XVIII, and Title XIX.	

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet D-1 Computation of Inpatient routine service cost	SSA-1562 Originally, Schedule E of SSA 1562 was used for this computation. It was replaced in 1972 for all hospitals by SSA-2570. SSA-2570 Calculation of inpatient routine service cost requires: 1) calculation of inpatient days applicable to Title XVIII Part A 2) Calculation of inpatient routine nursing salary cost 3) calculation of inpatient routine nursing salary cost differential applicable to Medicare 4) calculation of Medicare general patient care unit cost 5) calculation total inpatient cost and cost applicable to Medicare for ICU, CCU, and other special care units 6) bottom line yields total Medicare inpatient routine service cost (item 4-Item 5) 7) calculation of per diem cost and inpatient and routine service cost for Titles V and XIX.	same basis for calculations as SSA-2570 8 1/2% nursing differential is only for services to aged; not for services to disabled lines 20-26 provide for calculation of Section 223 limits	Note: Schedule D 1 includes the calculation of an 8 1/2% nursing salary cost differential This differential was terminated on April 17, 1975. If this is upheld, modifications will have to be made in this schedule.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet D2 Apportionment of cost of services rendered by interns and residents	Exhibit J of SSA 1992 or Exhibit 9 of SSA 9554	Includes total cost of services rendered and then allocates cost of services of interns and residents not in approved teaching program between adult and pediatric, ICU,CCU, nursery, subproviders and home health agency.	
Worksheet D3 Apportionment of hospital based physician remuneration for professional services	Exhibit H of SSA 1992	Divides charges and applicable professional service remuneration for diagnostic radiology, therapeutic radiology, radioisotope, pathology, anethesiology, electrocardiology, and eletroencephalography between Title V, Title XVIII, Title XIX, and kidney acquisition	
Worksheet E Calculation of Reimbursement Settlement - Title XVIII Part A and B services	SSA-1563 For each special service cost center: Total billed inpatient charges for all patients and Medicare patients; % of Medicare charges to inpatient charges; total patient expenses; and inpatient expenses applicable to Medicare Routine Service Per diem added in and non-allowable expenses deducted; Results in balance due to hospital from Medicare	Part I computation of net cost of Medicare covered services (allowable costs) Part II computation of lesser of Reasonable Cost or Customary Charges (this section draws on charge information from provider's records).	This section separates allowable costs from non-allowable costs and implements Section 233 of the 1972 amendments which limit reimbursement to the lesser of customary charges or reasonable costs. The sequence for completing Worksheet E varies depending on whether provider is proprietary, non-proprietary, or public.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet E continued		Part III Computation of Reimbursement Settlement for hospital, subproviders, and skilled nursing facility. Bottom line is balance due provider from Medicare program.	
Worksheet E1	not included	Analysis of Payments to Providers for Services Rendered to Title XVIII Beneficiaries (summary of all interim payments to provider)	
Worksheet E2	SSA-1563 Calculation of Reimbursable Bad Debts	Calculation of Reimbursable Bad Debts Title XVIII - Part B	Only bad debts incurred by Medicare beneficiaries are allowable costs under Medicare
Worksheet E-5 Part I, Part II and Part III	Not Included	Calculation of Reimbursement Settlement for Title V and Title XIX with computation of net cost of covered services, computation of lesser of reasonable costs or customary charges, and computation of reimbursement settlement. A separate copy of the worksheet should be completed for Title V and for Title XIX	The sequence for completing E-5 varies depending upon whether the provider is proprietary or public, or non-proprietary private. For proprietary providers, supplemental Worksheet F (Balance sheet for computation of equity capital) must also be completed.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet G Balance Sheet	SSA - 1563 Assets and liabilities for general fund, temporary fund, endowment fund and plant fund.	Current assets (cash on hand, accounts receivable, temporary investments, etc.), fixed assets (land, equipment, etc.) and other assets (deposits on leases, due from owner, etc.) broken down by general fund, specific purpose fund, endowment fund and plant fund. Current liabilities (accounts payable, salaries, etc.) and longterm liabilities (mortgage payable, unsecured loans, etc.) broken down by type of fund. Total fund balances	Same information - just uses different format, SSA-2552 displays information on all funds on one page.
Worksheet G-1 Statement of Changes in Fund Balances	SSA - 1563 Fund balance, net income (loss), additions, and deductions reported by general fund, specific purpose fund, endowment fund, and plant fund.	Fund balance, at beginning of period, net income (loss), additions, deductions, and fund balance at end of period reported by general fund, temporary fund, endowment fund, and plant fund.	Same information requested on both forms.

Section & Title Form SSA 2552	Old Cost Reports (various forms)	New Cost Reports (SSA-2552)	Comments
Worksheet G2 Statement of Patient Revenues and Operating Expenses	SSA-1563 Inpatient revenues reported for room and board, operating rooms, delivery rooms, x-ray, laboratory, oxygen, blood, etc., and outpatient revenues for x-ray, laboratory, electrocardiology, etc. Operating expenses broken down by administration, nursing, plant operation, operating room, etc.	Reports patient revenues from inpatient routine care service in hospital, subproviders, and skilled nursing facility and special inpatient care services in ICU and CCU. Revenue is also reported for ancillary service, outpatient service, home health agency, and ambulance. Operating expenses are reported from Worksheet A (only total requested).	Form SSA 1563 has much more detailed breakdown of revenues and expenses.
Worksheet G-3 Statement of Revenue and Expenses	SSA-1563 Statement of income and expenses same as SSA-2552.	Reports income from contributions, investments, telephone, parking lot, sale of drugs, vending machines, etc. Expenses are deducted from sum of income from above sources and patient revenues to obtain net income (or loss) for the period.	

Supplementary Worksheets for SSA-2552
(Optional)

D4 Apportionment of Remuneration applicable to hospital-based pathologists for Professional Services Reimbursable Part A

D5 Cost apportionment of ambulance services rendered by hospital

D6 Computation of kidney acquisition costs and charges supplementary to inpatient routine and inpatient ancillary service costs and charges.

E3 Application of Limitation on Outpatient Renal Dialysis costs

E4 Recovery of Unreimbursed cost - other than new provider

E-4-1 Recovery of Unreimbursed cost - new providers

F Return on Equity Capital of Proprietary Providers